Ombudsman

National Defence and Canadian Forces
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Report to the Minister of National Defence

by André Marin **Ombudsman**

SPECIAL REPORT

Systemic Treatment of CF Members with PTSD

Complainant:
Christian McEachern

Pursuant to the Ministerial Directives, September 2001

Canada

On the Cover

With his head buried in his hands, the man in the lower right corner of Colin Gill's 1919 painting, *Canadian Observation Post*, appears to be suffering from "shell-shock". Today, this condition is called post traumatic stress disorder (PTSD).

Canadian Observation Post
Colin Gill
CN8967
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Special Report

Systemic treatment of CF members with PTSD

PART ONE:
PREVALENCE OF PTSD WITHIN THE CF

PART TWO:
DIAGNOSIS AND TREATMENT OF PTSD

PART THREE:
ATTITUDES TO PTSD IN THE CF

PART FOUR:
GENERAL EDUCATION AND TRAINING ABOUT PTSD

PART FIVE:
DEPLOYMENT-RELATED TRAINING AND PROCEDURES

PART SIX:
EDUCATION FOR CAREGIVERS

PART SEVEN:
ADMINISTRATIVE RESPONSE

PART EIGHT:
SYSTEMIC ISSUES

Complainant: Christian McEachern

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Executive summary

Facts

1 The Ombudsman's Office conducted an investigation into a complaint by Corporal (Cpl) Christian McEachern that the Canadian Forces (CF) treats members who have been diagnosed with post traumatic stress disorder (PTSD) unfairly. Cpl McEachern, a former member of 1st Battalion Princess Patricia's Canadian Light Infantry based in Edmonton, was diagnosed with PTSD in the fall of 1997. He was released from the CF in July 2001.

2 On 15 March 2001, Cpl McEachern allegedly drove his vehicle into the Garrison Headquarters at Canadian Forces Base (CFB) Edmonton, for which he is facing criminal charges. My Office did not look into the immediate circumstances surrounding this incident, given that the matter is still before the Courts.

3 Cpl McEachern's primary concern was the way the CF deals with issues related to PTSD. He stated that there is insufficient understanding about, and awareness of, PTSD in the CF, that he and others received little or no training and education about PTSD, and that members diagnosed with PTSD are often ostracized, stigmatized and abandoned by their units. He indicated to my investigators that he was not seeking personal redress, but hoped his complaint would help improve the situation for others who are suffering from PTSD.

4 The investigative team interviewed approximately 200 individuals. Of these, approximately 100 were current and former CF members who had been diagnosed with PTSD, as well as a number of their family members. The team also interviewed members of Cpl McEachern's chain of command, including his former Commanding Officer and the current and former Commanders at Land Forces Western Area in Edmonton. Team members interviewed senior personnel at National Defence Headquarters, including the Director General of Health Services, Brigadier-General Lise Mathieu. The investigators interviewed staff members at three CF Operational Trauma and Stress Support Centres (OTSSCs), as well as members of outside agencies including the International Red Cross and foreign militaries. They also consulted with Lieutenant-General (retired) Roméo Dallaire and met with then Chief of the Defence Staff (CDS), General Maurice Baril. The investigation generated thousands of pages of interview transcripts.

Investigators also reviewed a large number of documents about PTSD from both the CF and other sources.

Findings

5 As the investigation progressed, it quickly became apparent that a number of issues arising from Cpl McEachern's complaint are systemic in nature.

6 The first issue that the investigators sought to ascertain was the prevalence of PTSD within the CF. They obtained information from individual OTSSCs about the number of cases of PTSD each had dealt with; for example, by May of 2001, the OTSSC in Edmonton had diagnosed over 200 CF members with PTSD since its inception in the fall of 1999. However, the CF psychiatrist in Edmonton estimates the actual number of CF members suffering from PTSD is far larger, given CF members' reluctance to come forward to seek help. Her 'worst case scenario' of CF members who may have PTSD is in the region of 600 to 700 in Edmonton alone. The investigative team was surprised to find that the CF does not possess a centralized database that accurately reflects the number of CF personnel who have been diagnosed with PTSD. Clearly, it is difficult to deal with an issue without sufficient data to indicate the extent of the problem. Furthermore, little or no data about suicides of CF members appears to be available. I believe it is essential to remedy the absence of data if the CF is to come to grips with PTSD and related issues and have made several recommendations in that regard.

7 Investigators examined attitudes to PTSD within the CF and found overwhelming evidence that many within the CF are sceptical about whether PTSD is a legitimate illness. There was a distressingly common belief among both peers and leaders that those diagnosed with PTSD were 'fakers,' 'malingers' or simply 'poor soldiers.' On the other hand, the evidence from medical professionals and caregivers indicated that exaggerating or faking symptoms of PTSD is rare, in the region of one to three percent. Furthermore, it became abundantly clear during the course of the investigation that the vast majority of CF members diagnosed with PTSD, including Cpl McEachern, were far from 'poor soldiers' — in fact, most were above-average or excellent soldiers. A former CF psychiatrist with considerable experience in the field told us, "Some of these guys are the best soldiers you will ever see." Nevertheless, we found that members with PTSD are often stigmatized, ostracized and shunned by their peers and chain of

command. These attitudes inevitably lead to a reluctance to seek treatment on the part of those with symptoms of PTSD. Attitudes towards PTSD within the CF are of particular concern, since the sooner members seek treatment, the more likely they are to recover and remain productive members of the CF.

8 I found several success stories, in which CF members diagnosed with PTSD continued in their careers as effective and valuable members of the CF. In virtually all cases, the key deciding factor was unconditional and nonjudgemental support from peers and the chain of command. This was a win-win situation for both the member and the CF, given the need for retention of experienced personnel. These success stories were, however, the exception to the rule.

9 In many cases, including that of Cpl McEachern, there was inadequate contact between members diagnosed with PTSD and their units, particularly once members were removed from their units and placed on the Service Personnel Holding List. Members with PTSD often felt they had been abandoned by their units. I have made a recommendation that units contact members on a formal basis, which I believe will reduce this perception. I also recommend that units be given sufficient resources to permit them to look after members within their units as far as is possible.

10 Improved education about PTSD is required to change attitudes towards PTSD in the CF, particularly among leaders. The CF has recognized that education is an important issue in dealing with PTSD, but sufficient resources have yet to be allocated to achieve this goal. This investigation found that a tremendous amount of work still needs to be done to educate CF members at all levels about PTSD and its ramifications. I recommend that appropriate mandatory basic and continuing education and training programs be put in place as soon as possible. I further recommend that education and training about PTSD be made a priority.

11 The delivery of such training exclusively by academics or CF caregiving professionals who have not shared the experiences of their audience does not appear to be an effective approach, despite the best of intentions. I therefore recommend that future training be delivered by multidisciplinary teams that include CF members who have been diagnosed with PTSD.

12 In contrast, the investigative team found that training and procedures related to deployment are being vigorously and positively supported by the chain of command. Significant improvements have been made in the quality and quantity of

deployment-related training at the unit level since Cpl McEachern was last deployed in 1996, at least in units that my investigators visited. I recommend that the CF audit and assess the effectiveness of improvements in training and procedures, particularly with respect to Reserve Force members who, we heard, often fall between the cracks in the system.

13 The investigation also concluded that caregivers must be trained to deal with PTSD, and I recommend the CF provide the incremental resources necessary to achieve that purpose.

14 A number of administrative issues also arose from this investigation. I recommend that the CF amend the rules regarding Occupational Transfers to accommodate members with PTSD, as far as is possible.

15 The CF also needs to improve support for family members of those diagnosed with PTSD. OTSSCs require more resources to fulfil their objectives, including delivery of outreach training, and I recommend that the CF investigate methods to deal with stress and burnout among caregivers created by the lack of resources and high caseloads. Serious concerns about the confidentiality of medical information need to be reviewed and addressed.

16 Finally, it is evident that no mechanism exists at present to allow CF leaders, educators, caregivers, family members and others to communicate and share the knowledge necessary to address PTSD on a holistic basis. I have therefore recommended the position of PTSD co-ordinator be created to remedy this deficiency. The person appointed should report directly to the CDS, outside of the normal chain of command. I appreciate that this reporting relationship is unusual, though by no means unprecedented; however, the consequences of the problems associated with PTSD are so significant to the CF, they require an exceptional solution.

17 I am pleased to note that the CF has been proactive in dealing with PTSD in many respects. The Department of National Defence (DND) and the CF have introduced a number of initiatives to attempt to deal with issues related to PTSD. Not least of these is the creation of the OTSSCs. There was almost universally positive feedback from all quarters about the OTSSCs, with particular praise for the astounding dedication of those who work in them. I also commend the chain of command for giving rapid approval and support to an initiative to develop peer support groups for members with PTSD, and for introducing a case manager system to improve continuity of care.

18 PTSD is an operational hazard that is a fact of modern peacekeeping missions. It is not going to go away. Indeed, the CF Surgeon General recently told the Standing Committee on National Defence and Veterans Affairs that "PTSD is clearly one of the most significant health problems that our members face." While there are still many unknowns about the causes of this disorder, it may be that the very qualities that make Canadians effective as peacekeepers in the world's trouble spots also make them susceptible to psychological injury. To maintain operational effectiveness in peacekeeping, the CF must take the initiative to lead other nations' militaries in dealing with the prevention, identification, diagnosis and treatment of PTSD.

19 PTSD is not a new problem, nor is it one that can be avoided. It is the cost of Canada's continued involvement on the world stage as a nation committed to preserving peace. The cost of this commitment should not be borne by the men and women of the CF. It is a national responsibility, one that the leadership of the CF and DND must make a priority.

20 I conclude that Cpl McEachern's complaints were justified. As is the case for many CF members who suffer from PTSD, he was stigmatized and isolated from his unit, without the support from his peers that could have sustained him. I hope that the recommendations in this report will significantly improve the way that the CF deals with PTSD.

Introduction

Complaint

21 Corporal (Cpl) Christian McEachern was released from the Canadian Forces (CF) on 23 July 2001 after over six years of service with the Regular Force and over seven years of service with the Reserve Force.

22 Cpl McEachern has been diagnosed with, and treated for, post traumatic stress disorder (PTSD) and, before his release, had been medically classified as permanently unfit to work in any military environment. He was posted to the Canadian Forces Base/Area Support Unit (CFB/ASU) Edmonton Medical Patient Holding List (MPHL) on 18 January 1999. The MPHL has since been renamed the Service Personnel Holding List (SPHL).

23 Cpl McEachern faces criminal charges after allegedly driving his vehicle through the front entrance of the Edmonton Garrison Headquarters in the early hours of 15 March 2001. Pursuant to Section 15 of its mandate, the Ombudsman's Office cannot look into the immediate circumstances surrounding that incident given that the matter is still before the Courts.

24 This investigation began by focusing on Cpl McEachern's primary complaint that the CF treats members with PTSD unfairly.

25 However, to provide a context for the way Cpl McEachern was treated, the investigation had to examine how the CF deals with PTSD for all of its members. It quickly became apparent that there are numerous systemic issues relating to how the CF as an organization deals with PTSD.

26 To put Cpl McEachern's treatment by the chain of command into perspective, it was first necessary to determine the prevalence of PTSD, and how the illness is diagnosed and treated within the CF. Parts One and Two of this report examine these aspects of the CF's treatment of members with PTSD. Attitudes about PTSD in the CF are discussed in Part Three, while Parts Four, Five and Six examine different aspects of education and training about PTSD in the CF. Parts Seven and Eight examine the administrative response and systemic issues relating to how PTSD is dealt with by the CF. While every soldier's situation is individual, some general observations are offered, based on information gathered in the course of this investigation.

27 Cpl McEachern's complaint raised two main types of questions about how the CF handles PTSD:

28 *1. Is there a stigma in the CF against those identified as suffering from PTSD and is sufficient education and training about PTSD provided to CF members?*

29 Cpl McEachern complained that:

- 30 He received virtually no training or education about preventing and identifying stress-induced illnesses and, prior to his diagnosis, he had virtually no knowledge of PTSD. This lack of information contributed to his inability to recognize or understand the symptoms that he was experiencing.
- 31 Both before and after his diagnosis with PTSD, the chain of command ignored and/or regarded his symptoms as behavioural problems.
- 32 There is insufficient understanding and awareness of PTSD at all levels in the CF, and those identified as suffering from PTSD are generally stigmatized and rejected by their peers and the chain of command.
- 33 Members with symptoms of PTSD are reluctant to seek help because of the stigma associated with the disorder and the fear that, if they are identified as having PTSD, they will be pushed toward release from the CF.

34 *2. What is the administrative response to PTSD in the CF, and is it appropriate and effective?*

35 Cpl McEachern complained that:

- 36 The administrative response to PTSD in the CF is to treat those diagnosed with PTSD as "worthless" and to usher them "out the door," rather than to help them to recover and remain in the CF.
- 37 His request for an Occupational Transfer was refused, although it was recommended as essential to his recovery by his psychiatrist.
- 38 After he was put on the SPHL, Cpl McEachern felt alienated and ostracized from the CF when he did not receive any meaningful contact or other signs of support from his unit.

39 - After he was put on the SPHL, his medical treatment was scaled back because of a lack of resources that arose after his military psychiatrist, LCdr Passey, retired.

40 - Reservists are treated as second-class citizens within the CF.

41 - Post-deployment briefings and other measures designed to prevent PTSD and other stress-induced illnesses are not always carried out, or are carried out inadequately. Cpl McEachern stated that he received only a cursory debriefing prior to his return from deployment to Croatia in April 1994 and no debriefing on his return from deployment to Uganda in December 1996.

42 Part Seven examines some administrative issues that arose in Cpl McEachern's complaint that are important but may not apply to all cases, that is, annual leave policy, Occupational Transfers and transitioning soldiers off the SPHL (fit for release).

43 Part Eight of this report examines how Cpl McEachern and others diagnosed with PTSD are treated within this system. Specifically, the following systemic issues are addressed:

44 - treatment of Reservists and augmentees;

45 - the MPHL/SPHL;

46 - the Operational Trauma and Stress Support Centres (OTSSCs);

47 - care for caregivers;

48 - treatment and support for families;

49 - peer support concept;

50 - confidentiality of medical information;

51 - resource issues;

52 - co-operation and co-ordination challenges; and

53 - a co-ordinated approach to PTSD by the CF.

54 Notwithstanding his allegations of unfair treatment by the chain of command, Cpl McEachern indicated that his goal in lodging a complaint with this Office was not primarily the resolution of grievances arising from his personal circumstances. Rather, he

hoped that his complaint would help bring about systemic change to improve the situation for others who are suffering from PTSD.

Investigative process

55 Cpl McEachern's complaint that the CF offers inadequate support to members suffering from PTSD is not an isolated occurrence. The subject has sparked increased media coverage and public interest in recent years. It has also been the concern of a large number of inquiries to this Office from many members and former members who suffer from PTSD, some of whom have yet to disclose to the CF that they have been diagnosed with PTSD.

56 This Office is treating each complaint on an individual basis. Some complaints have been assigned to Ombudsman's investigators for further examination; others have been resolved by providing the appropriate guidance and referrals.

57 On 4 April 2001, I met with Cpl McEachern and his mother in Edmonton to discuss his complaint. My investigators formally interviewed Cpl McEachern on 9 April 2001.

58 As the investigation evolved, it entailed a wider examination of how members with PTSD are treated in the CF, and why those with symptoms of PTSD are reluctant to come forward for diagnosis and treatment.

59 Cpl McEachern's complaint was assigned to the Special Ombudsman Response Team, headed by Director Gareth Jones, at the beginning of April 2001. Shortly thereafter, Brigadier-General (BGen) (retired) Joe Sharpe was brought in to act as Special Advisor for this case. In addition, a number of Ombudsman's investigators across the country, including Liz Hoffman and Bob Howard in Winnipeg and Frank Harrison in Edmonton, conducted interviews and obtained material to expedite this investigation. The team was assisted by an articling student. The investigative team was augmented by retired Master Warrant Officer (MWO) Mike Spellen, who arranged a number of interviews with members and former members who have been diagnosed with PTSD, some of whom would not have otherwise come forward. His assistance and advice to the investigative team has been invaluable.

60 Over the course of the investigation, Ombudsman's investigators consulted with over 200 individuals, including:

61 - over 100 current and former CF members[1] who have been diagnosed with PTSD, as well as a number of their spouses;

62 - current and former CF members who are suffering from stress-related injuries but have not come forward to be treated, as well as a number of their spouses;

63 - other CF members, including members who served with Cpl McEachern;

64 - members of Cpl McEachern's chain of command at 1st Battalion Princess Patricia's Canadian Light Infantry (1 PPCLI);

65 - the former Assistant Deputy Minister (Human Resources – Military) ADM (HR-Mil), Lieutenant-General (LGen) Roméo Dallaire;

66 - the Chief of the Defence Staff (CDS) from 1998 through June 2001, General (Gen) Maurice Baril;

67 - the former and current Commander of Land Forces, Western Area (LFWA), BGen Ed Fitch and BGen Ivan Fenton, respectively;

68 - the Commanding Officer (CO) and members of the chain of command at 2 PPCLI;

69 - a cross-section of COs and members of Edmonton-based battalions of LFWA;

70 - senior CF Reserve Force officers;

71 - senior members of CF health services, including: the Director General of Health Services (DGHS), BGen Lise Mathieu; the Director of Medical Policy, Colonel (Col) Ken Scott; the Reserve Advisor to the DGHS, Col Marsha Quinn; and the Assistant Chief of Staff, Health Services Delivery (ACOS HS Del), Captain (Navy) [Capt (N)] Margaret Kavanagh;

72 - senior National Defence Headquarters (NDHQ) staff, including the Director of Human Resources, Research and Evaluation, Col Cheryl Lamerson;

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[1] The term CF member(s), as used in this report, includes members of both the Regular and the Reserve Forces.

73 • staff of three OTSSCs, located in Edmonton, Halifax and Valcartier;

74 • military padres;

75 • unit medical staff;

76 • the Special Advisor to the Chief of Land Staff (CLS) on PTSD issues (Operational Stress Injury Social Support, Director Casualty Support and Administration);

77 • CF social welfare officers;

78 • several Base and Wing Commanders;

79 • Military Family Resource Centre (MFRC) representatives;

80 • Army Lessons Learned Centre (ALLC);

81 • members of foreign military organizations, including the Israeli Defence Force Ombudsman;

82 • Veterans Affairs Canada (VAC) staff;

83 • the Medical Advisor for the International Red Cross;

84 • civilian health care providers who have provided care to CF members suffering from PTSD, including a former CF psychiatrist now in private practice; and

85 • a forensic psychiatrist and psychologist employed by a civilian police service.

86 In addition, the investigative team contacted educational and training establishments across the CF to determine what training is delivered to members about PTSD.

87 On three occasions, the investigative team conducted interviews in group settings for members diagnosed with PTSD, in some cases with their spouses present. These meetings were organized by OTSSC staff at Edmonton, Halifax and Valcartier.

88 Most CF members diagnosed with PTSD spoke to Ombudsman's investigators on condition of anonymity, as did a significant number of CF members who related personal experiences of stress-related events. There is clearly a fear of being stigmatized by association with PTSD among CF members at all ranks. It is important to note that a number of those who spoke to the

investigative team indicated that they were only willing to do so because the investigation was being conducted by an agency independent of the CF.

89 My investigators examined Cpl McEachern's personnel and medical records after having received his written consent. They also gathered and examined a wide variety of other material related to Cpl McEachern's case, as well as to the issue of stress-related injuries in general, including the treatment of PTSD in the CF and in other agencies. During the course of this investigation, extensive research was conducted on the diagnosis and treatment of PTSD.

Summary of facts concerning Cpl McEachern

A. Events prior to PTSD diagnosis

90 At the age of 12, Cpl McEachern joined the Army Cadets in Calgary. He states that it had always been his ambition to be a soldier in the CF.

Entry into Reserves

91 In February 1987, having achieved the rank of Sergeant and the position of Sergeant Major in the Calgary Army Cadets, Cpl McEachern joined the Primary Reserve, specifically the Calgary Highlanders, in the Calgary Infantry Unit.

Deployment to Germany

92 From 15 August to 23 September 1988, Cpl McEachern was deployed to Germany to serve in the 3rd Royal Canadian Regiment (Militia Augmentation) for Exercise Reforger. In an interview with Ombudsman's investigators, he stated this period was when his problems with the military started.

93 Cpl McEachern identified the problems he encountered at this time as "discrimination against people in the Reserves coming to work over with the Regular Force." Using very strong language, Cpl McEachern stated that "there's major discrimination. It's like being a scab worker to them."

94 After his return from Germany, Cpl McEachern stated, he was "shaken" by his experiences of discrimination, experiences that he described as a "blow."

Promotion to Corporal (Reserve)

95 On 9 June 1990, Cpl McEachern was promoted from Private to Corporal on the recommendation of his CO, Lieutenant-Colonel (LCol) A.G. Maitland.

Promotion to Master Corporal (Reserve)

96 In October 1993, Cpl McEachern was promoted to Master Corporal (MCpl) after successful completion of the Infantry Section Commanders Course at the PPCLI Battle School.

97 Cpl McEachern was evaluated as "highly recommended for UN duties" in his United Nations (UN) Pre-Selection Training Course Report of 2 October 1993.

Deployment to Croatia

98 From January to April 1994, Cpl McEachern was involved in predeployment training with 1 PPCLI. From April to November 1994, Cpl McEachern went on a six-month deployment with 1 PPCLI to Croatia in the sector south under the UN Protection Force (UNPROFOR).

99 Prior to his deployment, Cpl McEachern assumed the rank of Private in accordance with the normal procedure for Reserve soldiers. However, while on deployment in Croatia, Lieutenant (Lt) L.A. Gallinger "strongly recommended" Cpl McEachern for promotion from Private to Corporal, which was effected on 22 July 1994. As Cpl McEachern explains, "I was originally tasked as a platoon signaller but because of my strong infantry skills ... they moved me back down into a position where I could be in a leadership role overseas."

100 Cpl McEachern indicated that he experienced symptoms of PTSD while on this tour, saying his "first PTSD incident" was the death of a fellow soldier in a mine blast. Cpl McEachern indicated that he first began experiencing nightmares near the end of the tour.

101 Cpl McEachern described as cursory the debriefing his unit was given prior to its return to Canada from Croatia:

102

> It was pretty funny but ... the only debriefing that we had was ... I believe it was a medic and a padre ... it was only those two and our whole platoon. Basically the question was 'does anybody have a problem with what they've seen over there?' 'Does anybody feel crazy?' Of course nobody is going to say anything, you're in a room full of guys you just spent six months on the line with, you're not going to say anything ... you're not going to come forward and that was it. And there was no follow-up after that ... the only follow-up that we had on anything to do with the tour was ... we signed a piece of paper saying that we've been exposed to ... possible contaminants in the soil over in Croatia ...

Entry into the Regular Force

103 In November 1994, Cpl McEachern was offered direct entry into the Regular Force, which he accepted although it entailed a reduction in rank to Private. Cpl McEachern was assigned to B Company 1 PPCLI.

104 In a letter of recommendation for Cpl McEachern's entry into the Regular Force, Major (Maj) J.G. O'Brien wrote the following with regard to Cpl McEachern's performance with the 1 PPCLI during the six-month tour in Croatia:

105

> Corporal McEachern C.J. fit in well with his peers and was well recommended by his supervisors for his performance. He met the standard required of an infantry soldier in an often-trying situation, both physically and mentally.

106 In the period following his entry into the Regular Force, Cpl McEachern stated that he experienced symptoms of PTSD, but did not recognize his condition: "There were odd bouts of crying and depression. I didn't really know what it was. At this time I didn't know I had PTSD so I just shut up about it."

Promotion to Corporal (Regular)

107 In a letter dated 16 May 1996, Cpl McEachern's Platoon Commander, Lt George Boyuk, recommended Cpl McEachern for promotion, writing in part:

108

> During the one and a half years since Pte McEachern joined this Bn, his performance has been at a superior level, bordering on outstanding. Pte McEachern has been employed in different jobs at or above his rank level.

109 Cpl McEachern's promotion to Corporal was accelerated to 24 May 1996. On that day, Cpl McEachern's company was disbanded as a result of the battalion's move to Edmonton from Calgary and Cpl McEachern was promoted to Corporal on the disbanding parade. He was announced as top Private in the company.

110 Cpl McEachern describes his entry into his next company at 1 PPCLI as follows:

111

> Then I walk into my … next company and the first thing I hear when I walked in the door is "get the fuck out of my face, you fucking maggot." I just worked for two years to make a name for myself, working with ex-Joint Task Force Members, the ex-Airborne. I'd worked in a totally professional environment and then had gone back in to a completely abusive situation — most of the people hadn't been anywhere overseas yet, other than Cyprus. Over the course of the next couple of years, I was totally just singled out for being a direct entry, a quick pick. I was constantly passed over for career furthering courses.

112 Cpl McEachern stated that he believed that his career was impeded and his stress level was exacerbated by discriminatory treatment, first as a result of being a Reservist, and subsequently as a result of being a former Reservist. He stated:

113

> … I should have been promoted a long time ago … you'll see that when you look in my PERS [Personnel] file, almost every one of my write-ups is employed in a position typical of his MOC [Military Occupation Code] but not his rank. I mean how long do you have to go and get outstanding or superior leadership write-ups before you get promoted … ?

Deployment to Uganda

114 In 1996, Cpl McEachern was picked as one of ten members of his unit to deploy on "Operation Assurance" (Rwanda/Zaire) from 15 November to 31 December 1996, in position BG0034 (Machine Gunner) with the Defence and Security Platoon for the National Rear Link of the Combined Joint Task Force Headquarters.

115 Cpl McEachern's Platoon Commander, Capt George Boyuk, told investigators that, as part of the selection process, he interviewed all potential members of the team to assess whether they were suitable for the deployment. According to Capt Boyuk, Cpl McEachern assured him that he was mentally fit to be deployed. No formal predeployment screening process was conducted by trained professionals.

116 Cpl McEachern's comments suggest that he suffered significant anxiety in anticipation of his deployment to Rwanda. He stated:

117

> We were in a briefing, getting all the political lay-out and the factions and who's involved and what was going on. When the Sergeant Major was briefing as he'd been over there 1994, he started tearing up during the briefing, I knew that this was going to be … a mess. So the next thing I know, I'm down in Trenton … pretty worried about it because we're going in under a [non-UN type action, which changes the Rules of Engagement] … This was different. I had pretty well a major panic attack the entire flight over. The medic had been over there already. He was puking in the gas mask bag beside [me].

118 Cpl McEachern's unit was forced to wait in Uganda, as they were not allowed to fly into Rwanda.

119 Capt Boyuk described their arrival in Uganda as follows:

120

> To make a long story short, that plane, that Hercules with Cpl McEachern did not touch down in Rwanda … Everybody knew that we were totally armed. That is why that plane was not allowed to land in Rwanda, because we were armed … We all link up and we move into Entebbe, the old airport. We set up shop there … A few days later they move us into Kampala … We will work out of the airport for the first weeks or so … Then we move into Kampala. They set up a pseudo compound … It is the multinational headquarters now moving into Kampala … We then move into — they were not five star hotels, contrary to

> popular belief. That was divisional headquarters that had that, and we felt uncomfortable. We moved in basically to a roadside hotel type thing, with the guys in the rooms. We operate out of there for about another week ...

121 Cpl McEachern described two incidents in which he witnessed disturbing violence while in Uganda:

122
> ... and then while we're over there, there were a number of incidents that happened where we weren't allowed to do anything about it 'cause we weren't in Uganda to do anything ... And then, there were a few other incidents that happened ... I think the one that bothered me the most was the night the woman got raped right beside our compound, we could see the whole thing and hear her screaming. I called in about three times and asked if I could interfere, fire a shot or do something and I wasn't allowed to do anything because security for the division compound could not be compromised, so ... we just had to stand there and watch. That bugged me, that was probably the worst, not so much the ... well, the act was pretty bad but not being able to do anything ... you trained hard to go over there and be able to make a difference and then they tie your hands like that ...

123
> When we were in Entebbe, the main base, the outer perimeter was occupied by Ugandan Military Police. We were doing internal security around the main gates with them, but also the main close security on the aircraft. There were about, at any given time, 10 Hercs parked on the runway, a couple of American gun ships and a couple of Navy reconnaissance aircraft. I don't know how much money's worth of equipment there was on that base, but we were providing security for that airfield. When I was doing the security rounds one night, we heard the sounds of this guy getting beaten. We were not armed because the Ugandan government would not allow us to carry our weapons. This caused us huge concern. I felt unable to defend myself and my partner.

124
> When I was doing the security rounds one night, we heard the sounds of this guy getting beaten. We went to investigate and caught the tail end of it and tailed the body to see where they were going to drag it.

125
> Then the shift change vehicle came around on one of the side roads and illuminated the body as they were

> dragging it across. That is when I knew that the guy was definitely dead because his head was twisted around the wrong way and the back of his head was all pulpy and one of his arms was fractured and bent in the wrong direction, and they were dragging him face down across a road.

126

> These two guys weren't too happy that the vehicle's lights were on the body — [we tried] to get the vehicle lights to turn off before these guys could get agitated ...

127 Ombudsman's investigators interviewed a CF member who was present when the latter incident occurred. He confirmed the incident and stated that:

128

> ... we saw a Ugandan Military Police Officer who was beaten and we think that they killed him near the airport in Entebbe ... apparently this fellow had fallen asleep on duty and the Ugandans were trying to impress us by how steadfast they were, so they beat him up there. He looked dead to me.

129 On the other hand, Capt Boyuk told Ombudsman's investigators that he was unaware of the first incident, although he had heard of a policeman being beaten. In terms of what soldiers were exposed to in Uganda, he stated:

130

> They were exposed to a different form of discipline in that the Ugandan army treated their subordinates differently than we treated ours, in that if a guy fell asleep on shift or wasn't properly turned out or something, the guys would show up and there were a couple of instances where the officer would beat a guy with a stick, very archaic forms of discipline that obviously we didn't do ourselves. There were no open beatings, of a guy being dragged out on his feet or anything like that ... In that sense, yes, you saw a couple of strange things. But again, there were no executions. There were no public beatings. There was an incident I remember downtown that some of the guys en route to the airport witnessed, in that a shoplifter or something was chased down through the market and the police basically fired into the crowd to try to get this guy. A couple of people were shot. I remember the guys talking about that. They thought that was pretty brutal, innocent guys. One guy was eating his lunch and he was killed. He got a bullet and died. I don't know if Corporal McEachern was part of

> that. But this is the extent of the ... and I have seen worse things on the news here back in Canada.

131 During the course of the investigation, Ombudsman's investigators were told on several occasions that Cpl McEachern was 'never in Rwanda.' There was a clear implication that he could not therefore have witnessed anything so traumatic as to cause PTSD, the inference being that Cpl McEachern was exaggerating or faking his symptoms. Based on the evidence gathered during the course of this investigation, it is clear to me that:

132 - At no time did Cpl McEachern ever claim, to Ombudsman's investigators or indeed to any other party, that he was deployed in Rwanda;

133 - There is overwhelming evidence that Cpl McEachern witnessed disturbing violence while deployed in Uganda;

134 - Cpl McEachern is being honest, truthful and forthright in all his dealings with this Office.

135 Cpl McEachern stated that there was no debriefing on the unit's return from Uganda. When asked specifically if the debriefing process on return from Africa was any different than that followed on return from Croatia (which he described as cursory), he stated: "There was no process from Africa ... not even that."

136 Capt Boyuk stated that, after the return from Uganda:

137

> We do our post-exercise interviews, talk to the guys. I had concerns with a couple of guys who had obviously lied about their personal situations. That was my focus, my main effort administratively, to sort them out before too much time passed. Basically, the guys, because it was Christmas time, it was basically "if you have any concerns, come to me now. We will get a social worker to speak to you. For those of you who don't have any concerns" — and everyone wants to get home for Christmas basically.

138 Cpl McEachern indicated that his experiences in Uganda increased the severity of his PTSD symptoms. He stated:

139

> ... After I stopped the mefloquine [malaria medication], I was starting to get nausea ... severe chest pains and I was getting really bad night sweats and ... headaches and ... I started to have more severe symptoms. So I came back and they really start to kick in about two weeks after I stopped my mefloquine

> cycle and to this day I still think that mefloquine is what triggered the more physical side effects of the PTSD.

PTSD diagnosis

140 In the summer of 1997, CPL McEachern was posted to Wainwright as a section second in command (2IC) of a Regular Force basic infantry course at the PPCLI Battle School. The increased severity of his symptoms prompted Cpl McEachern to seek medical help. In the summer of 1997, the Medical Officer (MO) in Wainwright, Capt J.W. Ramsahoye, examined Cpl McEachern and sent him to a specialist to rule out non-psychiatric causes. After follow-up, the MO referred Cpl McEachern to a military psychiatrist, Lieutenant-Commander (LCdr) G. Passey, for assessment.

141 Cpl McEachern described the symptoms that finally led him to seek medical help:

142

> I'd be out on a patrol with ... these guys doing a debriefing or just, you know, teaching my section patrolling skills out in the training area, and all of a sudden my heart rate would skyrocket up to a really high level ... I was physically exerting myself but I stayed in fairly good shape and know my target zones and stuff like that and my heart rate was going totally sky high. My chest pains were getting really bad, I was getting really woozy and faint-like and I was just like "okay, something's wrong with me, I feel like I'm going to have a heart attack." Simple things like 13 kilometres rucksack marches that were easy for me started to ... be a problem, so I went in, finally said something to the medics. They did put me in for all this heart testing to make sure my heart was okay, found out nothing was wrong and then they asked me if I'd been anywhere overseas and I told them ... they referred me to Doctor Passey who immediately diagnosed me with PTSD.

143 Cpl McEachern indicated that he had never heard of PTSD before LCdr Passey diagnosed him with the disorder in the fall of 1997.

144 At that time, LCdr Passey placed Cpl McEachern on a temporary medical category and allowed him to continue with normal duties.

B. Events following PTSD diagnosis

145 Cpl McEachern did not tell anyone he had been diagnosed with PTSD; in his words, he wished to "avoid the humiliation of having PTSD."

146 When asked why it would be humiliating to have it known that he suffered from PTSD, Cpl McEachern replied:

147

> Because they train you to be a tough guy. As soon as you've got PTSD, it is shown as a sign of weakness. Even though I was still performing in those critical situations well, that wasn't the problem. I was able to do my job, and do it well, but the effects of the PTSD gave me a hard time when I was not at work. PTSD is portrayed in the Army like — a good example is we run MILES gear exercises, the laser simulator stuff. Before you go on the exercise, they will give you an envelope with a card inside that describes your injury and how to act for the medic that is going to come up and take care of you. PTSD is a joke to a lot of people. The guy who got the PTSD card, who got hit, threw his rifle, took off his shirt, started dancing, la-la-la-la-la, like playing the crazy clown sort of thing. I don't remember ever doing that. I just remember crying and thinking, "This is getting out of hand," and quietly kept it to myself.

Assault Pioneer Course — Wainwright

148 Cpl McEachern's next task in the early summer of 1998 was participating in the Assault Pioneer Course in Wainwright, Alberta. During this course, he experienced what he described as "really bad symptoms" of PTSD. According to his CO at the time, LCol Steve Bryan, this course was being used to help accelerate Cpl McEachern's promotion to Master Corporal: "My opinion of him was at the time very high … I was hoping for a good solid performance and I was really hoping he would be a star."

149 Cpl McEachern was removed from the Assault Pioneer Course in Wainwright after an incident in which he walked off a demolition range. According to Capt Boyuk, who was present during the incident, Cpl McEachern became angry and walked off the demolition range after being told by a Master Corporal acting on instructions from Capt Boyuk, that he was "not pulling his weight." Capt Boyuk characterized Cpl McEachern's reaction as "throwing a temper tantrum." Cpl McEachern was handed over to a Warrant Officer (WO), who took Cpl McEachern back to Camp Wainwright. Cpl McEachern was sent back to Edmonton where he was interviewed and put on sick leave.

On leave

150 Cpl McEachern stated that, during the period before he was put on sick leave, he experienced great frustration at being expected by his supervisors to perform at "150 percent" while performing at "100 percent." Cpl McEachern described the events that led to his being put on stress leave as follows:

151

> So over the course of the next year, I continued with work and at this point now I was triple tasked with like three different jobs. I was sigs NCO in the field, I was sigs NCO ... or sigs 2IC, NCO in the Garrison ... I was a swing instructor on a leadership course and I was just starting my pioneer, my explosive course within the battalion and I was going down the toilet now from stress and, you know, my depression was really bad. I was about four, five days to go on my pioneer course ... and again they're used to me working at 150 percent, I was always a 150 percent guy, now I wasn't performing at 150 percent, my 100 percent wasn't good enough even though I was still in the top third in the course and running candidate for top candidate, they weren't too happy about the fact that I was having to go to the [medical facility] a few mornings to get medication ... They started bugging me about my work ethic, and I started crying and I turned around and walked off the course.

152 Cpl McEachern stated that his unit (1 PPCLI) did not find out until June 1998 that he was suffering from PTSD, although "they had some idea I was going to see a psychiatrist." He also felt that the chain of command should have been advised that he was in treatment for PTSD, and that informing his superiors of his condition shouldn't have been left up to him. As he stated, "That's not my responsibility to walk up to my Major and say I'm suffering from PTSD." Cpl McEachern also stated that "your Section Commander should know, your Warrant should know but then if everybody knows then you're immediately ostracized and treated differently."

153 Cpl McEachern stated that he was disappointed and hurt by the fact that he did not hear from his unit after being put on stress leave, and indicated that moral support would have been beneficial to his recovery. As he put it:

154

> I got put on stress leave and pretty well continued with that up until January 1999. I tried to go back to work for a month but I couldn't; I couldn't do it anymore. At that point, it was basically a boot out the front door. I didn't even get a thanks for coming out, nothing. It was just totally humiliating, the whole experience. To this day, I still haven't heard anything from my unit. I'm going to now because the General is not happy … This all adds to the PTSD because when you're going through PTSD … one of the big things they say for recovery is that it's important that the guy remains close to and feels a part of his unit for recovery, and that is not happening at the unit level. They are kicking us out the door faster than we can say PTSD. Not even a "thank you." It's been three years since I've left my unit, I didn't even get my "thank you for your good service to the regiment" certificate. I know it's only a piece of paper with my name typed on it but … it's a humiliating experience having to admit that you're having problems and they're adding to it by ostracizing you immediately from the unit as a waste of rations. That really bothered me because I did feel that I had a pretty good record as a soldier and all I wanted was a "thank you, hopefully you'll get better." Maybe they could have called the unit that I was placed in or abandoned in for just the moral support — "How you doing, you're hanging in there, you're getting better, here's your Regimental Certificate, thanks for coming out, here's your medal, you're getting a medal, we're going to present it to you, etc., etc." The army's mentality right now … is that we were being taken care of by our unit. But my unit wasn't an ASU. I'm not a administration clerk, I'm an infantry soldier and to me the support needs to come from my unit, 1 PPCLI … and that's not happening and that's not happening for anybody that's coming out of this right now.

155 However, Cpl McEachern wishes to make it clear that since the incident on 15 March 2001 the regiment was present at his release and did present him with his Regimental Certificate. In his words, "at the very end, they were there."

156 According to Cpl McEachern, it is important that a member recovering from PTSD not feel like "a waste of rations" and to continue to feel "a part of his unit." At the same time, he did not feel that he could return to his unit because "they just kept tasking me harder and harder ... until at the time I got sick I'd been doing three or four jobs at once."

LCdr Passey recommends Occupational Transfer

157 In the fall of 1998, LCdr Passey assessed Cpl McEachern as unfit for employment in all combat arms Military Occupation Codes (MOCs).

158 In a letter written to the Base Personnel Selection Officer (BPSO), Garrison Edmonton, on 30 September 1998, LCdr Passey stated that Cpl McEachern's struggle with PTSD was a direct result of military service, and he strongly recommended an Occupational Transfer (OT) as part of a strategy of "effective medical treatment" for Cpl McEachern. LCdr Passey wrote, in part:

> **159** I have already forwarded a letter to the Commanding Officer of 1 PPCLI in reference to Cpl McEachern. He is suffering from a medical condition as a direct result of his deployment to a special duty area while on UN Peacekeeping. His condition coupled with lack of appropriate recognition for his work to date with this Unit has significantly affected his effectiveness as an infanteer. I do not believe that he will be able to continue as an infanteer, and I strongly recommend that he be considered for reclassification to another MOC as soon as possible. I feel that a reclassification will be the only way that he can continue to be employed in the Canadian Forces.
>
> **160** I believe that Cpl McEachern is a prime example of what General Dallaire has said about effective medical treatment of the troops, as well as appropriate support from the Canadian Forces. We have an opportunity to implement that type of strategy with this individual and so I ask that you carefully consider the request for reclassification. A reply at your earliest convenience would be appreciated.

161 In a letter dated 15 October 1998, LCdr Passey wrote to the CO of 1 PPCLI, urging him to consider a Career Review Board (CRB) to look at an OT for Cpl McEachern. LCdr Passey wrote, in part:

> **162** Cpl McEachern continues to suffer from PTSD, depression and a degree of panic disorder. It is in my opinion that his employment as an infanteer is exacerbating his condition and making appropriate treatment very difficult if not impossible. For this

> reason, I feel he is unfit for employment in all the combat arms MOC's. Given his past work ethic, dedication to duty, and experience as an instructor I feel that his release from the Canadian Forces would be a great loss. Furthermore, I feel that he is fit for employment in any trade except the combat arms. I request that you consider a CRB with a view to having him reclassified into a different MOC. This would salvage his career and ultimately would save the military a significant amount of money by not having to retrain another individual to his level.

163 In an interview conducted for this investigation, LCdr Passey was asked about his efforts to obtain an OT for Cpl McEachern. He responded:

164

> McEachern is a prime example of someone that never needed to be where he's at ... If Chris [Cpl McEachern] had been able to do that [Occupational Transfer] you wouldn't have heard anything more, it would have given him a way of re-establishing his self-esteem, respect because the only thing he ever wanted to be was a soldier ...

C. Response of unit

165 LCol Bryan, then Cpl McEachern's CO, wrote to NDHQ on 11 January 1999 requesting that Cpl McEachern be transferred to the MPHL, now known as the SPHL. In his letter he referred to the recommendation for an OT made by LCdr Passey, noting that such an action "would be premature."

166

> LCdr Passey has indicated that the member's current employment in the infantry MOC is exacerbating his condition and making appropriate treatment very difficult, if not impossible. Doctor Passey has recommended an occupational transfer to a non-combat arms MOC "as a way to salvage the member's career and aid in treatment of his condition." Given that his current medical status deems him, as a minimum, temporarily unfit under the Universality of Service criteria ... any move toward occupation transfer would be premature. By placing the member on the MPHL, we should be able to set the conditions for future success by providing Corporal McEachern an environment in which he can pursue the treatment he

> needs and deserves. The Brigade Surgeon fully concurs with this approach.

Transfer to the MPHL

167 In January 1999, Cpl McEachern was transferred to the MPHL at the request of LCol Bryan.

168 Cpl McEachern's medical category was changed to a G5T6 and the following limitations were noted on a "Notification of Change of Medical Category or Employment Limitations" form dated 19 January 1999:

> **169** Unfit sea, land, UN, or isolated. must see physician Q< [every] 3 weeks.
>
> **170** Member not to undergo any stressful event work related.
>
> **171** Not to handle live fire weapons.

172 In response to Cpl McEachern's new medical category, LCol Bryan recommended that Cpl McEachern "be employed in MOC with restrictions."

173 Cpl McEachern stated that, after he was put on the MPHL, his weekly visits with a physician for counselling and monitoring of his medication were scaled back to one appointment every three months, which he feels had a deleterious effect and impeded his recovery from PTSD. This situation was due to LCdr Passey retiring. He attributed the decrease in the frequency of his treatment to

> **174** a system that's overwhelmed … they've got one psychologist for 200 people on the base, there's only so many times you can get fit in … They're trying their best. Even though they're probably burning out with the workload they're getting and … from my point of view ... three months in between your medication checks is too long. A lot can happen in three months.

Instructor at Army Cadet Summer Training Centre

175 Despite the fact that his employment limitations included a restriction on handling live fire weapons, Cpl McEachern was employed as an instructor at Vernon Army Cadet Summer Training Centre (VACSTC) located in Vernon, British Columbia, from 30 June to 24 August 1999. Cpl McEachern indicated that he volunteered to teach at the army cadet camp in order to gauge how well-equipped he was to return to work.

176 In a Performance Report dated 17 August 1999, LCol F.R. Daigneault favourably reported on Cpl McEachern's performance as follows:

> 177 1. Corporal McEachern was employed as a C7 Cadre Instructor and as a Firing Point Coach at Vernon Army Cadet Summer Training Centre from 30 June to 24 August 1999. His duties included the instruction of C7 to cadets, the co-ordination of C7 training with cadet companies, and ensuring the safe conduct of cadets firing C7 on the range. His performance during this period was *superior*. (Emphasis added)
>
> 178 2. Corporal McEachern displayed superior instructional capabilities and always ensured that the cadets had an excellent understanding of the C7. He was well respected by both his peers and superiors, and set a superior example for all to follow. Corporal McEachern is a likeable junior NCM [Non-Commissioned Member], who is very confident, and has excellent speaking skills. He willingly accepts new responsibilities, and is obviously driven to improve himself as a soldier and as a leader. He worked well with the cadets on the range and was very patient with those that were nervous or having difficulties. He is a highly professional soldier, and his physical condition is outstanding.
>
> 179 3. Corporal McEachern impressed all the staff at VACSTC and is highly recommended for employment here in the future.

Major White replaces LCdr Passey as primary psychiatrist

180 In February 2000, Maj Wendy White replaced LCdr Passey, who retired from the military, as the primary psychiatrist for Cpl McEachern.

Change in medical category and recommendation for release

181 Maj White recommended Cpl McEachern for a permanent medical category on 18 August 2000.

182 On 5 September 2000, Cpl McEachern's medical category was changed to a G5O5 and the following limitations were recorded on

a "Notification of Change of Medical Category or Employment Limitations" form:

183 *Unfit sea, land, UN, isolation postings* [however this was crossed out and initialled by the approving MO, LCdr P. Wahl].
184 Requires specialist Care [sic].
185 Unfit any military work environment.

186 Subsequently, Cpl McEachern's CO, LCol Curry, recommended his release.

D. Events following recommendation to release

Administrative review of medical employment limitations

187 On 16 November 2000, after completing an Administrative Review of Medical Employment Limitations (AR/MEL), Lt (N) L. Bertrand of the Director Military Careers Administration and Resource Management (DMCARM) recommended that Cpl McEachern be released on the basis that he did not meet the Universality of Service principle and that there was "no possibility of accommodation." The DMCARM decision cited the following employment limitations:

188 (1) requires regular specialist follow-up
189 (2) unable to tolerate the stress of working in any military environment
190 (3) to wear prescription lenses as directed

191 On 4 December 2000, Cpl McEachern was briefed by Capt Colleen Tizzard (the officer in charge of the SPHL in Edmonton) on the intention to release him from the CF. In accordance with *Canadian Forces Administrative Order* (CFAO) 34-26, Cpl McEachern was given the AR/MEL disclosure package, consisting of all materials that would be used by the Approving Authority in reaching a final decision as to his release, subject to the exemptions required by the *Privacy Act.* He was also given an opportunity to make written representations and submit materials. In a letter dated 3 January 2001, Cpl McEachern declined to make any representations.

192 On 11 January 2001, a decision was rendered by DMCARM that Cpl McEachern would be released 3B — Unfit Trade and not

Advantageously Employable — effective 3 July 2001, on the basis that he did not meet the Universality of Service principle. The DMCARM decision (AR/MEL-DMCARM Decision-R84 365 896 CPL CJK McEachern-031 INF) stated:

193

> Subsect 33 (1) of the NDA [*National Defence Act*] provides that all mbrs of the CF are at all times liable to perform any lawful duty. This means that every mbr of the CF must be able to perform a number of common specific military tasks, commonly referred to as the Universality of Svc (U of S) requirement, as well as occupationally specific tasks. The performance of the common specific military tasks are bona fide occupational requirements (BFOR) for all mbrs of the CF and one's medical fitness to serve in the CF is determined from one's ability or inability to perform these tasks. The common specific military tasks include a requirement for all its mbrs to tolerate the stress of all types of environments including military ones. Cpl McEachern's employment limitations do not meet all the BFORS associated with subsect 33 (1) of the NDA. Therefore, neither retention nor OT can be considered, release is the only alternative.

Presentation of Humanitarian Service Medal

194 In early March 2001, Cpl McEachern expressed concerns to Capt Tizzard, both in a personal interview and through several voice messages, as to when he would receive his Humanitarian Service Medal for his service in Africa in 1996. Cpl McEachern had seen his medal in the orderly room. He told Capt Tizzard that he did not want a formal ceremony and, after several calls, she agreed to his request. He stated that "if my unit wasn't going to present it to me, I didn't want a formal presentation."

195 On 14 March 2001, Capt Tizzard happened to see Cpl McEachern visiting Edmonton Garrison Headquarters on administrative matters, and called him into her office, where she presented him with the medal.

Annual leave

196 The issue of annual leave entitlement may have directly contributed to the incident on 15 March 2001 that resulted in criminal charges being made against Cpl McEachern. After presenting the medal, Capt Tizzard briefed Cpl McEachern on the requirement to expend his annual leave for 2000–01 before using sick leave. Cpl McEachern wanted to have his annual leave added to his accumulated leave and to cash out the total accumulated leave. Capt Tizzard explained the policy that states soldiers on the SPHL cannot accumulate leave until they are above their career accumulation limit. Cpl McEachern had just reached his career accumulation limit, but was not yet above it. He signed his leave pass before leaving Capt Tizzard's office.

197 The SPHL policy on leave is open to some interpretation, as recorded in the Administrative Review ordered by the Commander of LFWA BGen Ed Fitch following the incident involving Cpl McEachern on 15 March 2001. Several directives had been issued. In 1998, NDHQ had directed and funded a mandatory cash-out of leave for members on the MPHL who had reached their career accumulation limit of 20 or 25 days, depending on years of service. In January 2000, when the MPHL became the SPHL, the policy was continued with the added provision that members on the SPHL, unlike other CF personnel, were not required to take annual leave. Members on the SPHL therefore anticipated that they would be able to accumulate and cash out annual leave when they retired. Another direction, issued in August 2000, stated that members on the SPHL were subject to all provisions of CFAO 16-1, implying that they were not exempt from the overall policy. Not surprisingly, the requirement for SPHL personnel to take their annual leave was not recognized and Capt Tizzard continued to advise members that they could accumulate and cash out annual leave. However, in mid-March 2001 (with just weeks left in the leave year and very close to the date of Cpl McEachern's release), the policy was clarified and Capt Tizzard began informing SPHL personnel that accumulation of annual leave would only be authorized under extreme circumstances, and that they must use it by 1 April 2001. This change was of particular concern to Cpl McEachern as he had already budgeted the annual leave money that he had been told he could expect.

E. Events of 15 March 2001

198 On 15 March 2001, in the early hours of the morning, Cpl McEachern is alleged to have driven a civilian sport utility vehicle through the front entrance of the Edmonton Garrison Headquarters. The Significant Incident Report generated as a result of this incident indicated that the main orderly room area, including the orderly room and Integrated Relocation Pilot Project (IRPP) workstations, received the brunt of the damage.

199 No one was injured as a result of the incident. Soon after the incident, the Military Police (MP) arrested Cpl McEachern at the Edmonton Garrison Headquarters and took him to the garrison MP facility for processing. According to the Significant Incident Report, a breathalyzer test indicated that Cpl McEachern's blood alcohol count was over the legal limit.

200 The MP then took Cpl McEachern to the garrison clinic for a medical assessment, following which he was transferred to the Psychiatric Unit of the Royal Alexandra Hospital for further assessment.

201 The Significant Incident Report stated that the Edmonton Garrison Headquarters building was decreed safe for re-occupation by noon that same day, and administrative services resumed the next day — 16 March 2001. The report also indicated that members employed in the Edmonton Garrison Headquarters building would be offered Critical Incident Stress Debriefings (CISDs) on 16 March 2001.

F. Events following 15 March 2001

202 Cpl McEachern was charged under Section 253 of the *Criminal Code*. Cpl McEachern has retained counsel to represent him in these matters.

203 Cpl McEachern was released from hospital on 28 March 2001. He is currently living in Edmonton.

204 Ombudsman's investigators interviewed Cpl McEachern in Edmonton on 9 April 2001.

205 Cpl McEachern indicated that, since the incident of 15 March 2001, BGen Fitch has been in contact with him and has awarded him two medals, his CF Decoration and the CF Peacekeeping Medal. However, Cpl McEachern indicated that he is unhappy he did not receive any acknowledgement of his military service until after the incident that led to criminal charges against him. He feels that, without the occurrence of the incident and the ensuing media coverage, he would not have been awarded these medals for a much longer time.

206 Cpl McEachern described his condition as follows:

207

> Recently I have been back to panic attacks again. I get panic attacks when I am driving. Loud bangs kind of set me off, startle me. My depression has been really bad the last year. Several incidents that didn't involve the accident the other night, they have the same blackout situation. I will get in my truck and drive around and I will cry and I feel trapped. I feel humiliated, and I just want to get out of here, but I can't. I will drive to one end of the city and want to leave the city, and then say, "No, okay," and drive home, but I am not ready to go back in the house yet because I am still crying. So I drive to the end of the city again and feel the same stuff and want to leave. I get into this blackout state of just like total numbness. I can't describe it. I guess you have to go through it to understand.

208 Cpl McEachern summed up his feelings about how the CF had treated him as follows:

209

> All I'm asking for, all I wanted, was recognition for my career and I wanted a pat on the back and I wanted to leave out the door like I contributed something to my country. Not like I was a waste of rations and a worthless soldier when I worked so hard to try to make a name for myself as a soldier.

Part One:
Prevalence of PTSD within the CF

210 There appears to be no centralized system in place that gives statistics as to the number of cases of PTSD in the CF. This is problematic, as it is very difficult to craft effective solutions to a problem without knowing the extent of the problem. Just as importantly, perhaps, lack of solid information about the prevalence[2] of PTSD within the CF can result in unwarranted scepticism about the existence of the problem.

211 Part One of this report addresses the prevalence of PTSD in the CF, while Part Two provides an overview of the diagnosis and treatment of the illness.

Historical prevalence

212 A common question, asked by both civilians and those in the military, is, "Why has PTSD emerged relatively recently in an era of small-scale conflicts when it was unheard of in earlier times when large-scale wars were fought?" Some believe that veterans of previous generations did not suffer symptoms similar to those of PTSD and that PTSD is a modern phenomenon that reflects a trend of victimhood.

213 On the other hand, the literature on military history is replete with references to stress-induced illnesses in virtually every conflict since records have been kept.

214 These historical studies and surveys of the experiences of Canadian war veterans challenge the perception that previous generations of soldiers did not experience stress-induced mental health problems. In fact, military historian, Dr. Allan D. English, who teaches War Studies at the Royal Military College, was commissioned to research this issue by the Croatia Board of Inquiry (BOI). His work, *Leadership and Operation Stress in the Canadian Forces*, published on the board's Web site, includes a history of the experience and treatment of stress in the CF starting with World War I. Furthermore, Peter Neary and J.L. Granatstein, in their book, *The*

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[2] The term prevalence is defined in epidemiology as the number of occurrences of a disease or event during a particular period of time. It is usually expressed as a ratio: the number of events occurring per the number of units in the population at risk.

Veterans Charter and Post-World War II Canada, published by McGill-Queen's University Press in 1998, discuss what they call "the problem of persistent emotional disabilities" among Canadian war veterans. They write:

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> As long as there have been wars, individuals have suffered from the after-effects of traumatic experiences. Stories of nightmares, involuntary trembling, and dramatic reactions to sudden noises are part of the lore of every combat veteran's family. Folk memory and literature, if not formal history, are full of examples of the returned soldier who became a burnt-out case, the promising young man who was never the same again, the chronic alcoholic who couldn't get over the war. The universal character of this phenomenon is easy enough to establish. What requires investigation are the intellectual and ultimately social constructs developed to explain the persistence of pain and the reality of chronic neurosis.[3]

216 The emotional and mental problems experienced by war veterans are commonly known as "shell shock." At the end of World War I, many Canadian veterans sought medical assistance for various symptoms resulting from the trauma of war. At the time, the psychiatric community labelled these as "neuroses," "neurasthenia" or "neuropsychiatric problems." Treatments varied from electric shock to psychotherapy. There are no statistics available for the exact number of Canadian veterans who sought treatment for war-related "neuropsychiatric problems." However, it is reported that by 1927, approximately 9,000 Canadian veterans were in receipt of pensions for "shell shock and neurosis" and thousands of others had applied for pensions on the same basis with success.[4]

217 Neary and Granatstein cite the following study as indicative of the prevalence of war-related mental disorders among war veterans:

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> One study of World War I veterans examined men who had enlisted in Waterloo County's 34th Battalion. Information was obtained on forty-six volunteers who served in France, and the author, Michael Wert, was able to link the personnel records of the survivors with their Veterans Affairs files, as well as with local funeral home records. Thirty-six survived the war, but thirty-one were wounded or invalided through sickness. Five of these suffered from "shell shock," two

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[3] At page 149.
[4] At page 150.

> from "neurasthenia." In the post-war period, sixteen of these men obtained pensions for varying periods, and almost all of the others sought pensions for physical ailments with accompanying psychosomatic symptoms. One veteran who received a 15 per cent disability award for deafness sought to increase his rate on neuropsychiatric grounds, claiming that bouts of depression and other symptoms were related. His application, which reveals a textbook case of what would now be called Post Traumatic Stress Disorder, was rejected, as were others [whose] case histories included similar problems.[5]

Current prevalence

Prevalence in the general population

219 The *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition[6] (DSM-IV), published by the American Psychiatric Association, is relied on by psychiatrists and other mental health professionals in North America to identify and diagnose mental disorders. With regard to the prevalence of PTSD, DSM-IV states:

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> Community-based studies reveal a lifetime prevalence for Post Traumatic Stress Disorder of approximately 8 percent of the adult population in the United States. Information is not currently available with regard to the general population prevalence in other countries. Studies of at-risk individuals (i.e., groups exposed to specific traumatic incidents) yield variable findings, with the highest rates (ranging between one-third and more than half of those exposed) found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide. [7]

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[5] At page 151. The study in question was originally reported by Michael Wert, in "From Enlistment to the Grave: A Case Study of the 34th Battalion's Experience with the Great War" (honours BA thesis, Wilfrid Laurier University, 1990).

[6] *The Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision. American Psychiatric Association: Washington, DC, 2000. Pages 463 to 468.

[7] *Ibid.* At page 466.

221 A much higher prevalence of PTSD is cited in *Treating Mental Disorders: A Guide to What Works,* published by Oxford University Press in 1999.[8] This text reports the lifetime prevalence of PTSD in the United States as 15 percent for the general population and twice that figure, at approximately 30 percent, among war veterans.

Prevalence in the CF

222 There are conflicting perceptions regarding the prevalence of PTSD in the CF. Some senior CF personnel, including medical personnel, believe the occurrence of PTSD in the CF is minimal and therefore easily managed. Others are convinced that there may be thousands of CF members with PTSD, whether diagnosed or undiagnosed, who may present a threat to themselves or to others. Generally, CF medical personnel acknowledge that there is simply no way to be certain of the prevalence of PTSD in the CF at this time owing, in part, to the lack of validated statistics.

223 At present, evidence relating to the prevalence of PTSD in the CF is largely anecdotal. Some CF health care providers believe the prevalence of PTSD within the CF is close to 20 percent of those who are deployed in peacekeeping operations or are exposed to traumatic events, while others estimated the figure at 13 percent. When Ombudsman's investigators attempted to ascertain the prevalence of PTSD in foreign militaries, they found a similar lack of statistics about serving members; however, anecdotally, an Australian Defence Force (ADF) psychologist estimated the figure at around 5 percent within the ADF.

224 Col Randy Boddam, the Director of Mental Health Services for the CF, interviewed as to the prevalence of PTSD in the CF, stated:

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> We don't know the numbers. We don't know the numbers in Canada, so we certainly don't know the numbers in the military. In part, in order to get a sense of how many people are suffering from, say, PTSD … it requires people to come forward. If you are a silent sufferer, you won't come forward.

226 LCdr Greg Passey, a psychiatrist now retired from the military after 22 years of service, did some pioneering work on the prevalence of

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[8] *Treating Mental Disorders: A Guide to What Works.* Peter E. Nathan, Jack M. Gorman, and Neil J. Salkind. Oxford University Press: New York, 1999. At page 152.

PTSD in the CF in the early 1990s. His work with the 2nd Battalion of the PPCLI in Winnipeg, Manitoba, covered a period prior to the battalion's deployment to Croatia and following its peacekeeping tour. Although preliminary in nature, his statistical study showed that the prevalence of PTSD rose from nearly 3 percent prior to deployment to 12 percent following the tour. During an interview with Ombudsman's investigators, LCdr Passey observed:

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> We were figuring on an overall rate of about 15 percent. They had close to 3 percent prior to going for a variety of reasons, then about another 12 percent but that was from one tour. We have had multiple tours. No one has done the research, despite us asking for that research to be done. No one has done the research to see the cumulative effect of multiple tours ... I would expect ... that our rates would be higher than 15 percent ... Fifteen percent I think is low. What is the upper limit? I don't know.

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> The initial research that David Crockett and I have done was a preliminary thing: What is the ball park figure of what we may see for depression and PTSD? Are they worth studying further? Yes, they are. Our depression rate is probably four times the general population. Our PTSD rate was five times the general population.

229 LCdr Passey was a dedicated CF psychiatrist who was held in high regard. While some members of the military medical community do not agree with his approach to PTSD or question the statistics he has collected, his work should not be dismissed unless empirically validated statistics prove otherwise.

230 Unfortunately, the uncertainty within the military medical community with respect to the prevalence of PTSD in the CF allows doubts about the validity of PTSD to persist and ultimately results in fewer soldiers coming forward to seek treatment.

231 Based on the sheer numbers of people that have come forward to talk to Ombudsman's investigators during this investigation, it is evident that significant numbers of CF members suffer from PTSD and, in too many instances, are released from the CF without having been diagnosed or treated for this illness.

232 In regard to the number of cases of PTSD in Edmonton, Maj Wendy White, the psychiatrist at the OTSSC in Edmonton, told Ombudsman's investigators that:

> 233 ... we don't have a real clear estimate about how many people actually experience PTSD. It's going to be really variable depending on the tour that you're on and how many tours you've been on, and what your personal experiences, your life experiences, have been ... for any significant missions you're looking at least 10 to 20 percent, that's for PTSD alone ... if you really look at people who maybe have partial symptoms or maybe have depression versus PTSD or an anxiety disorder versus PTSD ... then you're probably going for more like 20 percent up to, depending on the tour, up to about 50 percent ... So, about 3,000 as a rough estimate [out of 6,000 in the garrison] had been affected in some way. Not full blown PTSD but affected in some way. That would make 1,500, and even if half of those, or just less than half of those ... have [PTSD] ... I'm talking the worst case scenarios, we're still looking at between 600 and 700 people with chronic PTSD ... if you think for every person that comes in here, the majority will say, "I know two or three people that are suffering from the same kind of stuff, they just haven't come in," that makes 600 right there, so that would kind of fit with the rough guesstimate ... we've had over 200 people now and the majority of those people have been diagnosed with a chronic form of PTSD. And we don't even get everybody here, because there's the Garrison Psychosocial Clinic as well ... We don't even know about half of those people. So add on to the 200 ... another 100 ... I mean that's a rough guesstimate.

234 Several other CF caregivers to whom Ombudsman's investigators spoke indicated that, for every patient who was diagnosed with PTSD, there were likely between three and five other members who were symptomatic but would not seek treatment from the CF for various reasons. At that rate, there are possibly a thousand CF members with symptoms of PTSD in Edmonton alone.

235 In a similar vein, Ombudsman's investigators heard time and time again from members they interviewed during the course of the investigation that those diagnosed with PTSD may only be the tip of the iceberg; typically, CF members to whom they spoke felt that PTSD is quite common among their peers. In the words of one Master Corporal at LFWA:

> 236 PTSD is a problem and a lot of guys have it. A lot of guys won't admit it because they are scared ... They are having the same problems with their family and they are hiding themselves away. They are becoming

> hermits, losing their friends. A lot of my buddies are doing that.

237 Cpl McEachern stated that he knew of several members who believed they had a stress-related illness, possibly PTSD, but were unwilling to come forward because they feared the consequences.

238 Ombudsman's investigators found considerable anecdotal evidence that PTSD is widespread in some units and certain MOCs. In one unit investigators visited, three out of the seven physicians assistants had been diagnosed with PTSD. One senior Non-Commissioned Member (NCM) who was interviewed estimated that between 120 and 140 members of a recently deployed regiment had stress-related symptoms, possibly PTSD. Another senior NCM estimated that 50 percent of physicians assistants she knows are symptomatic or diagnosed with PTSD. She is certain from her own experience that there are far more members who are symptomatic who are unwilling to seek treatment from the CF. She stated, "There are a lot more people hurting out there, and are not willing to come forward. The system isn't friendly to us." Another NCM, who has not been diagnosed with PTSD, stated that four out of 60 co-workers in his support trade are clearly suffering from PTSD; he does not know if any of them have sought treatment. A senior officer told investigators that, of the 45 members of his Reserve Force unit who recently returned from deployment, he estimates between 15 and 18 have symptoms of PTSD.

239 An experienced CF social worker stated that:

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> I highly suspect that the actual numbers are greater based on my direct observations of sailors on the ships in the dockyard/base, and from what I hear — and overhear — from sailors about their comrades; many just don't come forward for help.

241 Certainly, some units are just not aware of the problem. Senior officers in a unit in a large urban area told Ombudsman's investigators that they were only aware of "a few PTSD cases" in the unit. However, an interview with a local CF social worker revealed 12 patients whose condition was psychologically related had been referred from the unit in the previous two months. Of those, eight were diagnosed with PTSD and four were awaiting diagnosis. The MO of this unit knew of nine PTSD cases within his unit, but based on information from social workers and others, he estimated 25 to 30 members of his unit may have been diagnosed with PTSD. A local VAC representative advised us that, based on her experience, the numbers were higher.

242 This is not a criticism of this particular unit's chain of command. They are precluded from knowing the exact number of those diagnosed with PTSD by rules of medical confidentiality (medical confidentiality is dealt with in Part Eight). While COs may not need details on particular individuals diagnosed with PTSD, they should have accurate data as to the number of members so affected. The lack of knowledge as to the number of those with PTSD, even within an individual unit, clearly illustrates the need for the CF to have more accurate data on the number of its members diagnosed with PTSD.

243 Based on the anecdotal evidence Ombudsman's investigators heard during the course of this investigation, it appears that most CF members diagnosed with PTSD were from the Land Forces. A significant number had more than one overseas tour. The investigators heard, again anecdotally, that many members who had been deployed in Cambodia and Rwanda had either been diagnosed with PTSD or had symptoms of the disorder. Furthermore, they heard certain regiments and MOCs had acute rates of PTSD, allegedly as a result of overtasking, and a large number of Reserve Force members from the early Yugoslavian tours had symptoms. Admittedly, such anecdotal evidence may or may not be accurate. A centralized CF database would enable CF leaders to decisively support or refute the anecdotal evidence. Collection of data on an ongoing basis is necessary to provide evidence so that leaders can make informed decisions about how best to deal with the issue of PTSD.

Prevalence among Reservists and other augmentees

244 Anecdotally, the prevalence of PTSD is reported to be higher among Reservists and augmentees, primarily because these members do not have the same support networks as members deployed with their own units. When asked whether his conclusions on the prevalence of PTSD in the CF would apply to the prevalence of PTSD in the Reserve component, LCdr Passey indicated that his research shows a higher rate of PTSD among the Reserve Force:

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> Our research suggested that it was actually higher than the Regular Force. No one has actually looked at that population. There has been absolutely no provision for assessment and ongoing care for reservists by the military. There is none ... If you are injured and you are a Reservist, you are not part of the total force; you are part of the civilian population.

246 The Reserve Advisor to the DGHS, Col Marsha Quinn, also commented on the greater susceptibility of Reserve soldiers and other augmentees to stress-related injuries. Col Quinn has had significant experience in working with PTSD and CISDs, as well as in commanding units that provided Reserve soldiers and augmentees to deployments. She stated that Reserve soldiers or augmentees who are sent on deployment with a Regular Force unit are more susceptible to stress because they are not part of the unit's "family" of closely bonded soldiers:

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> I think that in the population that wears a uniform who are augmentees, there would be a higher incidence. I would be very surprised if it wasn't. It has nothing to do — well, it may on the one side, but it doesn't have a whole lot to do with whether you are Regular Force or Reserve. It has a whole lot to do with that bonding thing and that family thing, and getting into the family ... There is no doubt. My view of this thing is coloured by where I am at any moment in time. If you asked me in the early 1990s where my guesstimate would have been from an augmentee's point of view, I would have told you that I believe that 75 percent of the people who came back had a problem, differing scales. Not all, "I'm going to jump out of a window" ... To "I don't know how I am going to handle this" ... Where do I think we are at this moment? If I were to look again from an augmentee's point of view, my guess would still be probably around 50 percent. I would have to be convinced that it wasn't ... I am not saying that everybody is off the 100 percent scale, but there are different degrees. A lot of that has to do with the whole augmentee thing. Desperately trying to fit in with the family, finally making it into the family, being dropped like a hot potato out of the family, and then having to regroup and join the other family which you left, whether it's your own personal family or your unit family.

248 It is clear, in my view, that however well-informed a particular military or medical opinion may be, the CF requires firm empirical data about PTSD, including prevalence among Reserve Force members and augmentees.

Statistical data

249 There is currently no centralized CF-wide process to collect up-to-date statistics on the number of current and former CF members

who have been diagnosed with PTSD or other stress-induced injuries. Several front-line caregivers identified the lack of statistics about PTSD as a serious impediment to planning for the future. They indicated that collection of comprehensive statistics would provide them with sufficient empirical information to make financially sound arguments for the provision of appropriate care, or as a senior OTSSC clinician put it, "the statistics from the OTSSCs, as a whole, on a quarterly basis, would be a voice in themselves." Furthermore, no centralized database exists to track treatment methods or outcomes.

250 Regular centralized and standardized collection of data about PTSD would have a variety of uses. For example, by identifying those most susceptible to PTSD, the data could be used to target education and training initiatives where they are likely to be most effective.

251 However, some work has been done to collect statistics from the OTSSCs. In January 2001, a survey entitled "Operational Trauma and Stress Support Units Statistical Synopsis" reported that the OTSSCs had seen a total of 875 patients in the 14-month period since November 1999. (This figure did not include patients waiting for a psychiatric assessment.) The prevalence of PTSD ranged from 10 percent in Esquimalt to 90 percent in Edmonton and Halifax. Based on the percentages reported by each OTSSC, 723 patients of the 875 patients seen were diagnosed with PTSD. However, the survey noted, these percentages represent an "educated guess for all centres."

252 The survey summarized its findings as follows:

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> Together, the five OTSSCs have seen approximately 1,000 patients since opening their doors in 1999 with rates of PTSD diagnosis varying from region to region across the country. It is evident that the majority of these patients are coming from land force units who have been the subject of multiple deployments to numerous locations around the globe, those most affected having served early on in the initial start up phases of operations. Also we are seeing a small, but significant number of CF personnel being affected by humanitarian support operations nationally and internationally in which sailors and soldiers are exposed to devastation beyond the norms of day to day service and Canadian family life.

254 The survey also recommended improved data collection. It noted that continued data collection "will permit us to better evaluate the full impact of clinical interventions and provide guidance to improve the numbers of treatment successes."

255 The survey raised two other issues. First, there is a need to standardize and define terms in collecting data; for example, while three OTSSCs seem to differentiate between operational- or deployment-related illness and non-deployment-related illness, two make no such distinction. Second, no data are available on methods of treatment employed by individual OTSSCs, or on how successful they are. As the survey noted, "None of the OTSSCs interviewed were able to provide quantitative data for treatment successes or failures ... Each of the clinicians interviewed mentioned the increased need for outcome measures research."

256 Other sources that could provide reasonably solid statistics about PTSD include SPHLs. In February 2001, out of 42 members posted to the CFB/ASU Edmonton SPHL, 19 had been diagnosed with PTSD. However, it should be borne in mind that many more members with PTSD likely remain in their units and are not diagnosed or posted to the SPHL. As the Officer Commanding (OC) of the Edmonton SPHL pointed out, "my assessment is that there are far more people continuing in the workplace than on the SPHL that are being treated for PTSD."

257 VAC is another possible source for data on PTSD. VAC already collects information on the medical condition of applicants, and it also has a strong interest in developing an accurate picture of the prevalence of PTSD in the CF. However, it must be remembered that the CF is primarily responsible for the welfare of soldiers deployed in support of Canadian national interests and for determining the extent of medical problems that such deployments generate.

258 When asked about the current state of data collection, the Assistant Chief of Staff, Health Service Delivery, Capt (N) Margaret Kavanagh remarked:

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> No, I don't think there is [any data collection]. ... We don't have good tools in the CFHS [Canadian Forces Health Service] for making it easy to do that ... Once the CFHIS, which is our information management system, comes in, it should make it a whole lot easier, but that is still four or five years down the road ... Is it good? No. Are we doing a whole lot? Probably not ...

260 While the introduction of the Canadian Forces Health Information System (CFHIS) is a step in the right direction, CF leaders must have solid statistics right now rather than later. They cannot wait for CFHIS to come on line: the CF must institute a system to collect data concerning the prevalence and treatment of PTSD within the CF as a matter of urgency.

Suicide statistics

261 Another important indicator of the prevalence of PTSD in the CF could come from suicide statistics. Anecdotally, a number of the soldiers interviewed commented on the high number of their compatriots who had chosen to end their own lives. One soldier believed that 11 CF members who had been deployed in Rwanda had committed suicide. Other soldiers were aware of peers who had attempted suicide but were prevented from doing so. Several members interviewed had themselves either attempted or contemplated taking their own lives. One soldier confided to an Ombudsman's investigator that he had contemplated suicide to avoid harming his family; another soldier graphically described how he had planned to take his own life but had been interrupted. Unfortunately, the CF does not currently maintain records from which suicide rates among those with PTSD can be readily extracted. When asked to provide this information, LCol Henry Matheson, the CF senior social worker, replied:

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> We have been tracking the number of suicides since the late eighties however have only been compiling each individual's deployment history since 1998 ... Keep in mind that the information we have on deployment history is only as good as the information held by Director Human Resources Information Management (DHRIM). I have some information on those individuals deployed prior to '98 but not necessarily the units that they served with. In order to respond to your inquiry we would have to cross-reference the names of those that were deployed with the 2nd Battalion of the PPCLI with the list of CF suicides since the deployment.

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> We rely on military police reports and the casualty notification from DCSA [Director Casualty Support Administration] to identify Reg and Res Force suicides. This serves well to identify the Reg Force but would not necessarily identify all the suicides among the Reservists as not all result in a Military Police investigation or a casualty notification notice.

264 Currently there is no system in place to track retired personnel. As a point of note, last year with the assistance of VAC we examined the list of ex-service members who are receiving a pension. Of the nine recorded suicides of pensioners in the past 10 years one had peacekeeping duties.

265 When contacted for information on the suicide rate for veterans, VAC indicated that it does not maintain such a database. Although VAC records number of claims by dependants that are believed to be suicides as a result of military service, the number is likely not even close to reality. Essentially, unless someone informs VAC that the death of a pensioner is a result of a suicide, it has no way of determining suicide statistics.

266 A staff officer who works at Director Casualty Support Administration (DCSA) described the difficulty of obtaining statistics on Reserve soldiers: "The casualty database tracks deaths of members on service and includes Reserve Force members if they die 'on service.' Reservists on Class C and B contracts are on service but Class A are considered on service *only* during a period of pay."

267 According to LCol Matheson, the CF does not at this time maintain a cross-reference between suicide statistics and deployment history. While there have been significant improvements in recording statistics for members of the Regular Force, there has been no corresponding effort for the Reserve Force. Neither is there any attempt to track retirees to collect suicide (or other health) statistics.

268 During the course of this investigation, the situation for a specific battle group from the early 1990s was investigated in detail to try to assess the suicide rate for one deployment. Despite considerable effort, it was not possible to produce definitive numbers for Regular or Reserve Force soldiers who had attempted or committed suicide since their deployment. However, it is clear that DND does not record all suicides: for instance, in one specific case a young soldier committed suicide on a CF base shortly after returning from a deployment, but although the event was clearly recalled by members of the unit, there was no record of the information.

269 To understand the extent of psychological injuries, the CF must begin to collect and understand the right statistics. Statistics about suicides and attempted suicides can provide important insight into how many CF members and former members are affected by PTSD.

Health surveys

270 The Croatia BOI recommended that the CF conduct "periodic health surveys of retired and serving CF members with emphasis on those personnel subject to deployments." According to the latest available update to the CDS on implementation of the recommendations of the Croatia BOI and the Thomas Report, the Health and Lifestyle Information Survey 2000 (HLIS 2000) has experienced distribution difficulties. The second distribution of HLIS 2000 began with a Request for Proposal for data entry and analysis issued on 30 March 2001. The survey was completed 1 May 2001, and data entry and analysis were completed 31 July 2001. Final distribution and public release of the results are scheduled for 15 April 2002.

Statistics Canada survey

271 According to the Director of Mental Health Services, Col Randy Boddam, the CF is contracting Statistics Canada to conduct an epidemiological survey to determine what is happening with respect to mental health issues in the CF compared with in the Canadian population as a whole. Statistics Canada was already planning to undertake the Canadian Community Health Survey (CCHS) in January 2002, with the actual survey to begin in April 2002 and the final report due in December 2002. The plan is to have the results generally available by the fall of 2003. The survey may provide an excellent measure against which to assess the prevalence of PTSD in the CF.

272 The Reserve Advisor to the DGHS, Col Marsha Quinn, is making efforts to include a Reserve component in the study, based on her experiences as a Reserve CO who sent soldiers on deployments. She stated:

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> Those experiences in the 1990s have certainly driven my latest crusade, which is to have Reserves included in the mental health survey that is going on. They had not budgeted for it. We are now in a battle for the million dollars that it is going to cost over and above everything for Stats Can to do the Reserves.

274 The Director General Operations of the Ombudsman's Office is an observer on the working group set up to create a framework for the CCHS. Several concerns are apparent about exclusively relying on the survey to ascertain the prevalence of PTSD within the CF. They are:

275 • The time frame. The survey is not due to be completed until 2003.

276 • The 'piggybacking' of mental health issues on an already extensive survey. Statistics Canada has also expressed some concerns in this respect.

277 • There is no plan for the survey to include former CF members, either Regular or Reserve Force.

278 At a session of the working group at CFB Petawawa on 23 August 2001, Col Randy Boddam updated the working group on the CCHS survey as a whole, the CF mental health supplement to that survey, and the efforts the CF is making to conduct its own survey to determine the one-year and lifetime prevalence of PTSD in the military. Col Boddam readily acknowledged the lack of awareness of the scope of PTSD within the CF. The CF mental health supplement to the CCHS survey will only include Regular and Reserve Force members who are currently serving. According to the Col Boddam, retired members are not considered part of the CF mandate. While there is some discussion that VAC could be involved to include retired members in the survey, at the time of writing the issue has not been resolved.

279 In my view, the proposed Statistics Canada mental health survey is a positive move, but to be fully effective, it must include those who have been released from the CF.

Summary and recommendations

280 In summary, solid data are needed to determine the prevalence of PTSD in the CF and the resources needed to address it. Effective policies to deal with PTSD in the military must be based on knowledge, not perceptions. In addition, the proper allocation of resources to treat PTSD and educate members of the CF about the magnitude of the problem depends on an accurate understanding and empirically validated data, rather than on misperceptions. In fact, the lack of reliable data on the prevalence of PTSD in the CF encourages perceptions among some members of the CF that the issue of PTSD is inflated or sensationalized. This effort needs to include at least an estimate of the number of members who do not feel comfortable coming forward with their symptoms.

281 I therefore recommend that:

1. **The Canadian Forces develop a database that accurately reflects the number of CF personnel, including members of both the Regular and Reserve Forces, who are affected by stress-related injuries.**

2. **The Canadian Forces develop a database on suicides among members and former members.**

3. **The Canadian Forces conduct an independent and confidential mental health survey that includes former members, as well as Regular and Reserve components.**

Part Two: Diagnosis and treatment of PTSD

Diagnostic criteria

282 PTSD has been included in DSM-IV since 1980. Previously, combat stress was included in a category called gross stress reaction or delayed stress reaction, described as a temporary condition. Symptoms included alcoholism, drug abuse and depression.

283 DSM-IV classifies PTSD as an anxiety disorder, characterized by specific symptoms following exposure to an extreme traumatic stressor, experienced either directly or indirectly (through observation or second-hand knowledge). According to DSM-IV, traumatic events commonly associated with the onset of symptoms of PTSD include, but are not limited to: military combat, violent personal assault (including sexual or physical assault), kidnapping, hostage-taking, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or human-caused disasters (e.g., earthquakes, fires, floods), severe automobile accidents, and diagnosis with a potentially terminal illness. More generally, PTSD may develop from any event that involves actual or threatened physical harm, where the individual experienced intense feelings of fear or helplessness.

284 DSM-IV lists six diagnostic criteria that must be present to establish a diagnosis of PTSD:

285 A. The person has been exposed to a traumatic event in which both of the following were present:

286 (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

287 (2) the person's response involved intense fear, helplessness, or horror.

288 Note: In children, this may be expressed instead by disorganized or agitated behaviour.

289 B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

290 (1) recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions.

291 Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

292 (2) recurrent distressing dreams of the event.

293 Note: In children, there may be frightening dreams without recognizable content.

294 (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).

295 Note: In young children, trauma-specific reenactment may occur.

296 (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

297 C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

298 (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

299 (2) efforts to avoid activities, places, or people that arouse recollections of the trauma

300 (3) inability to recall an important aspect of the trauma

301 (4) markedly diminished interest or participation in significant activities

302 (5) feeling of detachment or estrangement from others

303 (6) restricted range of affect (e.g., unable to have loving feelings)

304 (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

305 D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

306 (1) difficulty falling or staying asleep

307 (2) irritability or outbursts of anger

308 (3) difficulty concentrating

309 (4) hypervigilance

310 (5) exaggerated startle response

311 E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

312 F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

313 In addition to the above criteria, DSM-IV states that the following signs may be associated with PTSD:

- 314 painful feelings of guilt about surviving when others did not survive or about the things the individual did or did not do at the time of the trauma;
- 315 avoidance patterns;
- 316 impaired relationships with others;
- 317 marital conflicts, divorce and/or loss of job;
- 318 self-destructive and impulsive behaviour;
- 319 dissociative symptoms;
- 320 somatic complaints;
- 321 feelings of ineffectiveness, shame, despair, and/or hopelessness;
- 322 feeling permanently damaged;
- 323 a loss of previously sustained beliefs;
- 324 hostility;
- 325 social withdrawal;
- 326 feeling constantly threatened;

327 - a change from the individual's previous personality characteristics; and

328 - auditory hallucinations and paranoid ideation in some severe and chronic cases.

329 DSM-IV provides further information with regard to PTSD as follows:

330 - Symptoms usually begin within the first three months after the trauma, although there may be a delay of months or even years before symptoms appear.

331 - Symptoms may vary over time. In some cases, there is a waxing and waning of symptoms.

332 - In approximately half the cases, complete recovery occurs within three months after the traumatic event.

333 - If the symptoms last for more than three months after the traumatic event, the diagnosis is one of chronic PTSD, rather than one of acute PTSD.

334 - Symptoms may be reactivated in response to reminders of the original trauma, life stressors or new traumatic events.

335 - The severity, duration and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing this disorder.

336 - There is some evidence that social supports, family history, childhood experiences, personality variables and pre-existing mental disorders may influence the development of PTSD. A history of depression in first-degree relatives has been related to an increased vulnerability to developing PTSD.

337 - PTSD can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

338 - PTSD is associated with a higher risk of suffering from certain other disorders either prior to, concurrent with, or following the onset of symptoms of PTSD, specifically: Major Depressive Disorder, Substance-Related Disorders, Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Social Phobia, Specific Phobia and Bipolar Disorder.

339 It is important to note that not all people respond to traumatic events in the same way. All the experts whom Ombudsman's investigators consulted emphasized that different people perceive and react to the same event differently. One person may suffer PTSD because of an event or an exposure while others in the same circumstance do not, and it is not always possible to determine why. Moreover, individuals can be traumatized either directly, such as by being wounded or seeing friends killed or seriously injured, or indirectly such as by witnessing atrocities or seeing dead bodies.

340 The psychiatrist at a treatment facility that treats PTSD told Ombudsman's investigators of a World War II veteran who had been shot at and shelled. That did not cause his trauma. What did was the sight of a dead body in a burned-out tank. Similarly, caregivers told of trauma to peacekeepers caused by witnessing what happens to children in theatres of war and lacking the authority to offer tangible help.

341 Illustrative of the difficulty in identifying the causes of PTSD, Ombudsman's investigators talked to a soldier who had a serious accident with an armoured personnel carrier (APC) a few weeks before his deployment overseas on peacekeeping operations. The unit MO did not consider the accident worthy of a CISD because:

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> ... our main concern was to treat him medically ... I am not even sure I would have counselled him because it's more at the physical injury level than psychosomatic-type injury ... If you are involved in a motor vehicle accident, do we think does this person needs a CISD? Probably not.

343 The soldier was eventually returned to Canada during the deployment and subsequently diagnosed with PTSD. He had lain trapped under the APC for several hours, and his belief that he would never see his children again was the traumatic event. Failure to identify the stress-related trauma resulted in a forced repatriation with all the inconvenience and costs to the unit that entails; furthermore, it may have complicated the soldier's recovery.

Treatment of PTSD

Available treatment in Canada

344 Ombudsman's investigators found a multiplicity of medical treatments available in the general population in Canada and elsewhere for those who suffer from PTSD. Similar to the lack of firm data on the prevalence of PTSD in the general population, there is no conclusive data indicating which treatment for PTSD has the best potential for success. Furthermore, the medical community recognizes that no one treatment is suitable for all patients.

345 The CF is taking measures to develop standard approaches to treatment throughout the CF mental health services. According to Colonel B.K. O'Rourke, the current ACOS, Health Services Delivery:

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> As part of the Rx 2000 Project, we have established a Mental Health Team addressing all aspects of CF Mental Health services. In Sep 01, we are holding a working group meeting to look at establishing a common structure for the provision of Mental Health services, including the OTSSCs. Our objective is to standardize the processes, so that CF members are treated equitably and have a better understanding of what they can expect when they have a need to access our care.

347 I applaud and encourage such efforts.

348 Ombudsman's investigators heard high praise from both patients and medical personnel about the effectiveness of the treatment available at Homewood Health Centre in Guelph, Ontario. Homewood's Trauma Stress Recovery program is a residential six-week program that has been running for eight years. There are few, if any, equivalent residential programs in Canada. Between 30 and 40 CF soldiers have already taken the program, with mixed to good results. Ombudsman's investigators interviewed several CF members who had taken the program. The consensus was that the program was effective; however, several members pointed out that the program is not geared to CF members and suggested that Homewood create a program exclusively for patients with military-related PTSD. Another observation, made by both a CF psychiatrist and one of the patients interviewed, was that the residential program takes members away from their families for a considerable period of time, which can be problematic. In other words, the type of treatment offered at Homewood may not be suitable for all patients diagnosed with PTSD.

349 The psychiatrist who oversees the Homewood PTSD program discussed his general observations about military members who have participated in the program with Ombudsman's investigators. He stated that many of them indicated that they were extremely angry at the way they had been treated by the CF; they appear to feel that their peer group is not sympathetic and military culture is not conducive to members expressing their feelings; and they consider a diagnosis of PTSD as a professional "death sentence," inevitably leading to release from the military. His observations echoed many of the concerns that Cpl McEachern expressed to my investigators and myself during our conversations with him.

Common treatment methods

350 Exposure therapy is commonly used to treat anxiety disorders, including PTSD. The basic principle of exposure therapy is to teach the patient to respond to aspects of the traumatic event in different ways by gradual association of the stress-inducing triggers with neutral or pleasant events.

351 Anxiety management is also commonly used to treat PTSD. Anxiety management involves training patients to use an assortment of behavioural and cognitive strategies to improve their ability to manage the emotions (for example, fearfulness) and the behaviours (for example, aggressiveness) associated with PTSD. Strategies include relaxation techniques, breathing techniques, trauma education and communication skills.

352 Eye-movement desensitization and reprocessing is a relatively recent psychotherapeutic approach that uses eye movements to stimulate the brain's information-processing system. This treatment generally involves recalling the trauma, evaluating the negative images or memories, identifying an alternative interpretation of the memory, examining the physiological response to the memory, and employing a set of directed eye movements while the patient focuses on the traumatic memories.

353 Controlled studies of exposure therapy and anxiety management have proven to reduce symptoms and improve patients' conditions. Eye-movement treatment has not been as firmly substantiated by clinical studies and is controversial in some quarters.

354 Many different types of medications are used to treat PTSD, including monoamine oxidase inhibitors (e.g., Nardil), tricyclic antidepressants (e.g., Tofranil and Elavil), selective serotonin reuptake inhibitors (e.g., Prozac) and benzodiazepines (e.g., Valium).

Work therapy

355 Medical professionals whom Ombudsman's investigators interviewed cited meaningful employment as extremely beneficial to those recovering from PTSD: conversely, they stated, it is harmful for those with PTSD to languish on the SPHL for long periods. According to caregivers, treatment within the first three months of diagnosis is seen as critical to the individual returning to the work force, after which time the odds of successful reintegration are greatly diminished. From a treatment perspective, recovery is often facilitated if patients are making a positive contribution and feeling useful.

356 At the same time, however, the type of work must be suited to the individual's skill set and medical condition — soldiers qualified for combat expressed great frustration at being assigned such duties as sweeping the floors or tending the 'chip wagon.'

Summary

357 It is clear that qualified health care professionals are fully able to determine whether an individual suffers from PTSD according to an accepted set of diagnostic criteria. As many CF personnel pointed out during the course of this investigation, there is no blood test or X-ray that will physically prove PTSD, but it is beyond the expertise of the non-medical chain of command to determine whether or not an individual has the disorder.

358 The CF quite rightly places a premium on physical and mental toughness. CF members with PTSD who spoke to Ombudsman's investigators are also tough both mentally and physically. As one experienced military psychologist stated, "some of these guys are the best soldiers you will ever see." Yet something has happened to affect them so profoundly that they have become ill. They need and deserve the assistance of the CF to recover. The fact that a comrade who witnessed the same event has not been affected in the same way is irrelevant.

359 From the research conducted for this investigation, it appears that some approaches to treating PTSD are certainly questionable. It is important for the CF to thoroughly evaluate the efficacy of available treatments and standardize, if appropriate, the approach taken by CF caregivers.

Part Three: Attitudes to PTSD in the CF

360 Cpl McEachern told Ombudsman's investigators that, in his experience, the CF is unsympathetic to those with PTSD and that change is needed to improve understanding and awareness of PTSD at all ranks so that CF members diagnosed with PTSD can continue to contribute to the CF. He also stated that those identified as having PTSD are often stigmatized and rejected by their peers and the chain of command.

361 As noted previously, Ombudsman's investigators interviewed more than 100 CF members or former members diagnosed with PTSD and, sometimes, their spouses, as well as many individuals in the chain of command. For the most part, those who were interviewed told similar stories. They described little or no meaningful education about PTSD; a process of stigmatization, ignorance and resentment; and accusations of malingering, often culminating in release from the military. Most individuals who were interviewed did not want their units to know they had PTSD or a stress-related condition. Many CF members being treated for PTSD continue to perform their duties effectively in their normal workplaces. Notwithstanding the fact that many members continue to perform their duties, virtually all of those who were interviewed indicated they had lost trust in the CF and feared losing their jobs because they have, or may have, PTSD. Prejudicial attitudes toward PTSD in the CF are exacerbated by the fast pace of operations, which creates a reduced tolerance for those perceived to be contributing less than 100 percent effort.

362 The following issues, which are interrelated, indicate how the CF is perceived to treat members who have symptoms of or are diagnosed with PTSD:

363 - attitudes to PTSD at the unit and peer group level;

364 - lack of support from the member's unit;

365 - resentment toward members with PTSD;

366 - impact of personnel shortages;

367 - reluctance of members to seek help; and

368 - lack of trust in the CF.

Attitudes to PTSD at the unit and peer group level

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> To be quite honest, I would rather tell my peer group that I got the dose at a whore house than PTSD.
> Senior NCM, LFWA

370 A prejudicial attitude toward mental illness is certainly not unique to the military. The CF appears to have had no more success than civilian organizations in accepting and dealing with mental illness as a legitimate health issue. In my view, the failure to do so has created serious, systemic barriers to successful treatment of CF members diagnosed with PTSD.

371 Ombudsman's investigators discovered various attitudes toward PTSD in the chain of command and among peer groups. Some appeared broadly sympathetic, while others were extremely guarded; a few advised that they thought that there was little or no significant problem with PTSD in the CF. As for the stigma associated with mental illness, Cpl McEachern spoke of the "humiliation" of having a mental illness:

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> Basically I kept my mouth shut about it within the unit ... Why? To avoid the humiliation of having PTSD ... no one had come forward yet ... Because they train you to be a tough guy. As soon as you've got PTSD, it is shown as a sign of weakness.

373 Humiliation, and the stigma associated with mental illness, can have serious consequences for the careers of CF members diagnosed with psychological injuries. As one senior CF caregiver noted:

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> This non-acceptance of PTSD and other stress-related/mental health injuries is not restricted to supervisors. Many peers and subordinates also have a negative attitude towards a member who has any sort of mental health problem. We're like the general population in that sense, where the perception of an individual changes when it becomes known that the individual has a mental illness. Mental health and stress-related injuries are both misunderstood and treated with suspicion and contempt, those who have one are frequently the object of ridicule. It's as if they ... insulate themselves from the members for fear they might be likewise afflicted.

375 Col Randy Boddam, the Director of Mental Health Services for the CF, described the overall attitude toward mental illness as one of shame:

> 376 One of the things that came out of the [Croatia] Board of Inquiry as well as the Thomas Report was reduce the stigma. Great marching orders, but it is very difficult to do because you are asking people to change attitudes within the context of a larger culture, which has the attitude that our members have. When you add to that the fact that very often people will not get up on the rooftops and say, "I have a mental disorder," so there is a shame associated with it, it enforces it and they get into dysfunctional behaviours.

377 One senior MO described the attitude toward mental illness both in and outside the CF:

> 378 I still think there is a stigma attached to the concept of stress-related injuries and mental illness in general, both in the civilian world, as well as the military ... As has been reported often, it is okay to have a broken arm, but it is not okay to have a broken head.

379 Col Ken Scott, the Director of Medical Policy, also noted the stigma associated with mental illness in the CF reflects attitudes in society in general:

> 380 People would rather be diagnosed with terminal cancer than with depression as a cause of their symptoms. In our society we split [people with mental illnesses] off. Nobody wants a mental health diagnosis. It is a stigma. It is bad.

381 Medical professionals who treat soldiers on the front lines are not immune to these attitudes. According to Col Scott:

> 382 I am not going to exclude health care providers. There is probably some stigma in health care workers as well.

383 One soldier told Ombudsman's investigators of an occurrence at a medical facility. When he glanced at a poster on the wall about stress-related illnesses, the medic said, "Don't look at that, you will get PTSD," even though the medic knew he was there to get anti-depressants. The soldier remarked, "I didn't think it was much of a joke at the time."

384 The stigma also affects family members in the close quarters in which many military families live. Several spouses told investigators they were ostracized once their spouse's condition became known. One military wife, herself from a military family, told us:

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> It's just ugly, downright ugly, and the worst of it is how we're treated as human beings. We're not treated as human beings. We lost all our friends, military and civilian. The one military family we were really, really close with ... [the military spouse] found out [my husband] had PTSD and that friendship terminated. Until *he* got diagnosed with PTSD. [Emphasis added]

386 Ombudsman's investigators asked one psychologist who treats a number of CF members how patients react when they are diagnosed with PTSD. Her answer was typical of the views of every medical professional experienced in dealing with PTSD that Ombudsman's investigators spoke to. She described three different reactions:

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> I would say probably 50 percent know something is wrong. They don't know what it is, but they know that they are not doing well and they don't like themselves very much. Those 50 percent I would say probably accept the diagnosis and they say, "Okay, where do we go from here?" [Another] 40 percent feel that I have given them a death sentence and they call it poison that I gave them, poison ... They are very angry and very upset and initially they are worse, their symptoms are worse when I give them their diagnosis ... I told them something that could be leaked. Nobody knows they have it and they don't want it because then you're weak; you're not a soldier. Another 10 percent ... probably less than 10 percent ... [insist they] have some of the symptoms, but they don't have the full diagnosis of PTSD.

388 The incident involving Cpl McEachern has, to a degree, brought attitudes about PTSD out into the open. Ombudsman's investigators were told that "... the McEachern issue has sharply divided the base in Edmonton, with many people thinking that he is using PTSD as an excuse to avoid punishment. Others are more understanding." They encountered a number of CF members, including leaders, who — although they never met him and have no medical background — were certain that Cpl McEachern did not have PTSD.

389 Cpl McEachern felt his chain of command and his peers lacked compassion and understanding about PTSD. As he said, "it's a humiliating experience to admit you are having problems, and they are adding to it by ostracizing you immediately from the unit as a waste of rations." He described the reaction of the chain of command after the incident at Western Area Training Centre (WATC) that led to his diagnosis:

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> I think ... [that] Officers, because of their position and their rank, should be definitely somewhat trained, especially combat arms, in psychology and have to take a professional and compassionate approach to their soldiers when they do come forward with PTSD and not immediately chastise them or humiliate them in front of troops. I was pulled aside right in front of all my buddies when I started crying, where I should have been pulled aside perhaps that night and asked, "Hey, what's going on? You're not looking well. Is there something wrong? You're not acting like yourself lately." No. It wasn't anything like that. All of a sudden, it was just that I wasn't good enough any more ... That was my Pioneer course when I started crying and I walked off that course.

391 Overall, there is a perception that the most senior levels have a greater knowledge and awareness of PTSD than has been transmitted to the field level. In the opinion of one very senior medical staff officer, the level of awareness at the most senior level is quite high. "At that level [General Officers] I think their knowledge, understanding and appreciation for the issue has vastly improved. I am not so sure about my own level or that sort of Lieutenant-Colonel/Colonel level ... The intermediate seniors, I am not so sure."

392 A senior officer in the Reserve Force expressed a similar opinion:

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> Part of it is that although the chain of command at the top is very committed and does the right thing and says the right words, having been there at the lower level of the food chain, by the time the top says you have to do this and by the time Bloggins is standing on the armoury floor listening to blah, blah, blah, the message is totally different and the commitment to the message is totally different. To me it's those layers. You have to convince senior NCMs and the Majors and the Colonels that this is the right thing to do. If you do that, then you will get the inclusion. The generals have already bought in on it. The Colonels already

> understand, especially if they want to be generals. It's those other layers that really have to get out there and spread the message and say this is a good thing, and I personally, if asked, will sit there with someone and do it.

394 Many individuals at the immediate chain of command and unit level to whom Ombudsman's investigators spoke showed a poor knowledge and understanding of PTSD. Many in the immediate chain of command did not believe that stress-related health problems were a valid reason for an individual not to go to work. Some, when interviewed by investigators, expressed anger that soldiers on the SPHL were allowed to "sit at home all day and watch television" while other soldiers were working. One battalion officer described an incident during a training session on PTSD for officers and senior NCMs when a senior NCM got up in front of the group and commented, "How long are we going to allow these guys to suck off the hind tit?"

395 The investigative team found considerable anecdotal evidence that, within peer groups and the chain of command, many believe that PTSD is a weakness attributable to deficiencies in the person who has it, or that it does not exist at all. As one soldier put it, "Soldiers suffering from PTSD are considered by their peers as either 'nut cases' or malingerers who are trying to get out of their normal duties."

396 Other anecdotal evidence indicated that many in the chain of command, particularly those at the senior NCM level, are not as educated or progressive in their attitudes toward those with PTSD as one would hope. A senior CF caregiver told investigators:

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> My experience is that those with PTSD, or many other psychological psychiatric/psychoemotional problems, are frequently treated with disdain and ridicule. The primary culprits in this are the middle managers: the DivOs [Divisional Officers] and DivChiefs [Divisional Chiefs] and POs [Petty Officers]. Senior officers generally encourage members to get treatment and express that supervisors need to look out for their subordinates, although every now and again a unit CO will demonstrate an attitude — discrediting of a treatment, disbelief of a diagnosis, dismissing a member's needs as 'milking the system' or intolerance borne out of ignorance — which actually nurtures the unaccepting attitudes of the middle managers. This makes it difficult for treatment — it's not uncommon for a member to make good progress within our offices only to see the work undone by the unit supervisors.

398 Although others with intimate knowledge of the system expressed similar views, I wish to make it clear that I am not criticizing senior NCMs as a group. In fact, Ombudsman's investigators met several senior NCMs who fully understood the ramifications of PTSD, were extremely knowledgeable about the issues, and treated their subordinates with compassion and care. They met several senior NCMs who had gone above and beyond the call of duty to help members with PTSD. For example, Chief Warrant Officer (CWO), Frank Emond in Winnipeg, whose primary duties in no way required him to become involved, has personally intervened in many cases. This senior NCM does not discriminate based on service, location or severity of the disorder, and his personal efforts have no doubt improved (and possibly saved) many lives.

399 An infantry MWO, retired from the CF for seven years, has been the means whereby many soldiers from his regiment and others have been encouraged to seek help. He has touched many lives, and has undoubtedly saved some as well, placing both his civilian career and his own health at risk.

400 At CFB Wainwright, another MWO makes it his business to seek out members needing help and actively intercede on their behalf. At the same base, a junior NCM contacted this Office to express concerns for a fellow soldier with PTSD who was behaving in a suicidal manner. An Ombudsman's investigator was able to help the soldier with PTSD find assistance.

401 Similarly within the chain of command and peer groups, there are those who understand the issues and have a progressive approach. One NCM told us:

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> The Forces are divided in half, I think ... progressive individuals and then those stuck in what we call the old boys' system. And you cannot divide by rank any more. There are some senior NCOs and some officers at all rank levels who really can get themselves into the mind set and work it forward, think outside the box.

403 Many in the chain of command recognize the existence of stigmatization, and the repercussions that flow from it. Cpl McEachern's former Company Commander offered, in my view, a very sensible approach to dealing with members with PTSD. He told investigators:

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> What we have to do is recognize PTSD early. Have the full support of the chain of command to get the person

> to that treatment, and ensure that there is no stigma attached to admitting that there is a problem and to taking part in or receiving any kind of treatment. There cannot be any repercussions as a result of it.

405 At the same time, he commented that the system is currently far from perfect owing to cultural inhibitions: "People don't really know how to deal with [mental health] issues very well from a military perspective."

406 Ombudsman's investigators did encounter examples where the chain of command has taken pro-active steps to change attitudes. For example, BGen Ed Fitch, who was the Commander of LFWA when the incident involving Cpl McEachern occurred, was particularly committed to dealing with PTSD issues. I am hopeful that the efforts that he initiated to respond to issues related to PTSD are continued by his successor at LFWA.

407 It is encouraging to find leaders who continue to adhere to the fundamental principle of caring for their troops. Cpl McEachern is not the only soldier who has experienced a sense of isolation from his unit. Another Edmonton-based infantry soldier, with several deployments to his credit, commented, "Myself and that McEachern guy, we both left around the same time, but mine was a little more telegraphed all over the place. I knew everybody, so it was, 'Well, he's the crazy man,' and everything else" The investigative team heard time and time again from those interviewed that they felt abandoned by their peer groups as well as by their units once their illness became known.

408 The following comments, on the bias that exists against those with PTSD, by a member who has been a CF social worker for about 10 years and with the CF for about 20 years, were typical of what investigators heard from others in the military:

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> You asked how soldiers are treated by their peers, by their chain of command, by the military community. I would say that in all cases, it depends on who is the peer, the CO, or the community. I have heard examples where the soldier has been well treated on all fronts but this seems to be the exception. I think peers probably treat the soldier best because in all likelihood they've been there and can empathize best. I see peers protect and defend their own, offering support for each other, but not accessing helping services that are available because there is clearly little trust for resource personnel such as we social workers. During a brief trip to [an operational theatre overseas]

> I saw this many times: a soldier would ask a question about CIS [critical incident stress]/PTSD and I found out later they were asking on behalf of another soldier in order to safeguard their privacy and confidentiality.

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> I have heard service members with PTSD frequently comment on the negative comments they hear from supervisors or from other personnel they do not know. They feel they are routinely accused of malingering. They are often insulted, accused of being weak, of using the system, and ostracized by the unit. Their condition is frequently the source of amusement for others, who are often in a supervisory position. Others regard these folks with disgust and very little compassion. They make fun of the soldier and talk as if having to see a psychiatrist is some sort of wonderful benefit that they are being deprived of, without regard for the terrible suffering endured by our personnel.

Lack of support from the member's unit

411 The consensus among health professionals is that supportiveness at the unit level, including encouragement for seeking medical help, is one of the most important factors in recovery from PTSD. According to Col Cheryl Lamerson, the Director of Human Resources, Research and Evaluation:

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> If the message that is coming across to the individual in the unit is, "You're malingering or we don't believe you have this," that is not going to help. But if the message is coming across as, "Yeah, okay. You're on light duty essentially, but we are still glad you are here … We are not going to give you the message that you are irreparable. We are going to give you the message that, "You are coming back. It is okay. Take your time, but you are coming back."

413 Moreover, the CF as an institution acknowledges that support from the unit is a key factor in recovery. The 2001 *CDS Guidance to Commanding Officers* states:

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> Another very important issue is appropriate involvement of the chain of command in the care of a patient with mental illness. The influence of the workplace on CF members and their families is profound. CF members who are unable to perform to

> the maximum of their capabilities feel they have let the team down, and feel significant loss of self worth. During their recovery, they need to know that they are still accepted as a member of the team even if functioning at reduced capacity, and most importantly, that the team needs them to return to full functioning, and will support them in achieving this goal. Maintenance of contact with the unit and a desire to return to the unit are important factors in determining the ultimate outcome from many types of illnesses, including mental illness ... Mental illnesses represent a unique opportunity for unit members and the chain of command to assist in the process of returning a member to health ... The chain of command can assist the process by creating an environment in which acknowledging and addressing difficulties is promoted, in which the privacy of individuals is adequately protected, and in which individuals are supported in the recovery process.

415 Many CF members diagnosed with PTSD also identified support from the unit as a key factor in the recovery process. In many instances a member alleged he or she did not receive the support he or she expected. When Ombudsman's investigators asked him about support from his unit, Cpl McEachern stated that he received no meaningful contact from his unit once he was posted to the MPHL as follows:

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> Nothing, just we'll see you later, when I cleared out ... That is the problem. One would expect that the unit would at least say, "Good luck with your recovery, and we'll keep in contact to make sure you are doing well, etc.[9]

417 Other soldiers had similar complaints. One of the first soldiers interviewed in this investigation had done considerable research on military-related PTSD. In his view:

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> ... the most important single factor for recovery is the amount of positive support the member receives from his peers and unit. The greater the positive, the more support that's there that is real and believable, then the greater the number of people who will be able to return to that work environment. Without it, it won't happen. What the CF is not doing is closing ranks

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[9] The issue of contact between units and members on the SPHL is dealt with in Part Eight, under the section "Maintaining responsibility for the member on the SPHL."

> around their fellow members to provide tangible support, both for the member and for the family.

419 Another member diagnosed with PTSD told Ombudsman's investigators, "The day I admitted to suffering from PTSD, I was expecting support from the CF but that support wasn't there." A senior officer diagnosed with PTSD echoed his sentiment:

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> We are abandoning people, instead of banding together as a regiment should, because we are afraid of weakness. When Roméo Dallaire came forward, some senior officer said of him that he's "always been emotional," and to them 'emotional' is considered a weakness. The CF should introduce a total person concept and accept that people have weaknesses. We need to deal with PTSD as a military family. We have to get back to the family aspect of the CF.

421 A significant number of individuals with PTSD who were interviewed during this investigation agreed there is lack of meaningful contact or support from the unit. One remarked that, once his condition became known, "I was the person with the bubonic plague. My unit's attitude was 'let's not touch him.'" Another said he was "dropped like a hot potato."

422 Yet another member with PTSD told investigators that, although his CO has been extremely supportive and although he is well respected by his colleagues, he has kept the fact that he has been diagnosed from his peer group. He fears that he is more likely to encounter prejudice and ignorance about PTSD within the CF than support from the unit, which is important for recovery. As he stated:

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> I have to wear a lot of masks and keep my mouth shut. It hasn't been an easy thing. I am sure if I knew my peers were supportive, [if] I knew that I could count on the support of my peers and that they were sympathetic to my plight, my recovery would probably have been a lot better ... If they had the support of their peers and supervisors at work, I think you could integrate people a lot better into the system. They would feel that they are being cared for, their problems matter and you wouldn't have people being bounced out on stress leave for two and a half years or three years or whatever.

424 During this investigation, CF members with PTSD and their caregivers complained time and again about the lack of support from the unit. According to one senior caregiver, "The biggest part [of the healing process] is at the unit level. That support that you have, that's where the difference will be ... the big problem is not the treatment, it's the way that they are being treated at the unit level."

425 While the lack of support is not helpful, disapproving or punishing attitudes are actually injurious. Investigators heard of the chain of command openly humiliating members in front of their peers. Some members with symptoms or PTSD described their unit's treatment of them as so insensitive and malicious, it amounted to a secondary trauma that made the disorder worse. One member pointed out the irony in the situation: "I was totally mishandled. I was punished by my unit because I have a condition. I had to spend so much time away from recovering to fight the system."

426 Ignorance and the stigma associated with PTSD lead many unit members to treat their colleagues as if PTSD were contagious, a latter-day leprosy. One senior NCM described his unit's reaction to him once he was diagnosed:

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> I was completely ostracized by the battalion ... because most of them were afraid to have anything to do with us ... I remember a guy came up to me going, You know ... I don't want to say this, but I can't be caught talking to you.

428 He continued:

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> [If I went into the Sergeants' mess] I would probably be asked to leave. In fact I know that if the RSM [Regimental Sergeant Major] was in there now, or any of the Sergeant Majors, they would ask me to leave. When I was coming back [from treatment for PTSD], there was a Sergeant Major ... sitting right there, right across from me. I looked right at him. He looked away ... These were all people I used to work with. I think about it every day. It used to make me extremely angry. Now I have a calmer reaction to it. I can't blame them because, first of all, they don't understand. They can't understand ... I know what it's like to be ostracized because of a certain way or condition or colour or whatever.

430 When asked what could improve the situation for soldiers with PTSD, a professional with significant experience in treatment of PTSD emphasized the importance of the unit and the chain of command to recovery:

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> If they were supported instead of shunned. Support means a lot of different things ... We have some people in the chain of command who are excellent. They know that their members are sick, that their troops are sick, and they find them odd little jobs and put them in nice safe places.

432 It is important not to lose sight of the fact that there are many success stories — individuals who have returned to gainful employment within the CF after treatment for PTSD. Almost all of those the investigative team encountered shared one thing in common: these members had received prompt and non-judgemental support from their peers and chain of command. An experienced WO at a field ambulance unit expressed great appreciation for the support he received after he was diagnosed:

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> The unit has been excellent. The CO, the DCO [Deputy Commanding Officer], the RSM called me all the time. I had a call at least once a week from someone in authority. They understood. They helped me all the time. They helped me out a lot and I don't feel that I have been forgotten.

434 On the other hand, he added,

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> Most units do not do what my unit did. The infantry are completely different — they just don't understand.

436 One Master Corporal interviewed by Ombudsman's investigators described how her unit did everything possible to facilitate her recovery and return to work, including encouraging her to work part time. She described the support from her unit as "phenomenal." For instance, her chain of command consulted her when they were deciding whether she should be placed on the SPHL; she was told she could contact her chain of command at any time, 24 hours a day; and there was no pressure to return to work too quickly. As she stated, "I knew that people were there for me. I had the support." Ultimately, she was not placed on the SPHL. This soldier has since returned to work full time.

437 A member diagnosed with PTSD summed up the importance of support from the unit to recovery:

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> While it is true that most [soldiers with PTSD] require modified duties, and some are unable to deploy for future operational missions, the majority of individuals with the disorder are able to continue on in the

> performance of their duties. The most significant factor in this equation is the amount of positive support the member receives from his peers and his unit. The greater the positive support, the more support that there is that's real and believable, then the greater the number of people that will be able to return to the work environment. Without it, it won't happen.

439 While this investigation found some situations in which members with PTSD were well taken care of by the chain of command and/or their unit, unfortunately, in far too many cases, members with PTSD were not treated well at all. Ombudsman's investigators also observed that the chances of recovery were considerably enhanced when members with PTSD were well integrated into their units, but the prognosis was much less positive when units essentially rejected members with PTSD.

440 In many cases reported to the Ombudsman's Office, the units appear to have effectively abdicated their responsibilities for those with PTSD. Some soldiers expressed a sense of abandonment and resentment for not being recognized for their contributions. One infantry soldier with nearly 10 years of service stated:

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> Most people, even the officers over in the battalion, they don't give a — once you are gone, you are gone, you are expendable. When I left, they forgot about me completely ... They treated me like crap. They forgot about me. Every time I would go there and get something or buy something, they would make me feel like I didn't even belong, and I was still paying my dues ... I was never invited to nothing, so I just gave up.

442 Furthermore, increased understanding and respect for members with PTSD at the unit level will encourage others to seek help early, and maximize their chances of recovery.

443 It has been suggested that the chain of command has difficulty dealing with those with PTSD because the disorder is associated with feelings of anger, conflict with authority and victimization. Leaders may be reluctant to maintain contact with those with PTSD for fear of exacerbating the psychiatric condition. For instance, the adjutant at Cpl McEachern's regiment expressed the uncertainty as to whether members with PTSD want to be contacted. A CO told investigators of one instance in which a member on sick leave alleged contact by the unit amounted to harassment. As one senior NCM put it, "We are damned if we do and damned if we don't."

444 However reluctant leaders may feel, the evidence points to the importance of the unit's involvement in, and support for, the care of soldiers with PTSD. The practice of the Israeli military is to ensure that regular contact is maintained with members being treated for PTSD away from the unit. Or, as a senior health care provider put it:

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> The Canadian Forces health care system works the best to the patient's advantage when there is a triumvirate and when all three pieces are working together ... It is the patients themselves, the health care provider and the chain of command ... If the chain of command abdicates its responsibility, now you only have two of the pieces and it is not working as well.

446 Ombudsman's investigators often heard from medical personnel that a soldier is better off staying within the unit rather than being placed on the SPHL. In the words of one CO, "Instead, if you automatically move someone to the SPHL without trying to keep them in the unit, then what has happened is that you have exacerbated the problem."

447 Units can play a critical role in helping to reintegrate CF members with PTSD, according to a senior MO:

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> The units have a role in finding a way to allow these guys to come and work one hour a day, two hours a day, whatever it is, without demeaning it, because that is part of their therapy. It becomes therapeutic to make people go to work ... you can't wait six months.

449 While it appears recovery from PTSD is improved when members are retained with their units and employed in meaningful work with the objective of returning to duty, units are often hard-pressed to accommodate members' limitations owing to shortages of personnel and resources. Moreover, some members on the SPHL have severe employment restrictions that exclude them from any military employment. These members can frequently be assigned duties not associated with the military at all. Therapeutic activity and a gradual return to work are in the best interests of members with PTSD, but this approach has led to some resentment among their peers, as discussed below.

450 There is some indication that attitudes may be changing. For example, an experienced CO interviewed by Ombudsman's investigators is encouraged by signs of movement away from the stigma associated with psychological problems and toward retention in the unit as an increasingly viable alternative to the SPHL:

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> I was going to say that one of the things that I found encouraging was that the guys were talking about it [exposure to decaying bodies in Kosovo]. It wasn't everyone, but a good number weren't afraid to say, "Gee, this is pretty grim," and talk some of that stuff out. The stigma with, "Man, he couldn't take that," I think that is in some ways overblown. If it did exist — and it does exist to a degree — I sense that maybe we are moving away from that ... That would suggest that the conditions for a McEachern or someone like him to remain in the unit for a period of time ... is probably more positive than [someone] looking from the outside might suggest. "This would never work. We need to cocoon him." It would have to be looked at individually, but I sense the ground is probably more fertile for that type of solution than some would think.

452 In the fall of 2000, ASU Edmonton, with the cooperation of medical staff, studied a "back-to-work" program in which those on the SPHL were asked to come and work, either in a military or non-military environment and not necessarily in their previous jobs, depending on an individual's employment limitations. They could volunteer with local organizations or take educational courses. I understand that ASU Edmonton intends to launch this program in the near future.

453 I deal with systemic issues relating to contact between units and members diagnosed with PTSD in Part Eight of this report.

Resentment toward members with PTSD

454 One soldier interviewed for this investigation stated that a WO had told her PTSD stood for "People Trying to Screw the Department." She believed that perception of those with PTSD was not uncommon among her peer group.

455 There is undoubtedly considerable resentment toward CF members with PTSD, particularly those who have been removed from their units. A CWO related the resentment expressed by a senior officer after he had seen a soldier who had been placed on the SPHL walking his dog on a nearby beach. According to the CWO, the senior officer expressed others' resentment that:

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> All of the other [members of the unit] were coming in and getting very upset at that, because this individual, in the morning, would walk his dog, and he was happy. He didn't appear to be sick. The guys at work would wonder "what the heck is he doing? He's not sick, look at him go. He's running with his dog."

457 Unsurprisingly, resentment toward members with mental health issues on the SPHL is fuelled by the high level of operational demands on those who remain in the unit. In particular, the lack of replacements combined with no decrease or even increases in operational tempo creates antipathy toward those on the SPHL. As one senior NCM with several staff members on the SPHL noted:

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> It's the perception of the SPHL itself. It was designed if you have an individual who is unfit to work due to illness, sickness, be it mental or physical, for an extended period or duration of time, they were placed on SPHL ... and that section would have the person replaced.

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> Unfortunately, the system is grinding to a halt where the replacements are more difficult to come by, again leaving the units short.

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> If one person goes on SPHL, there is no one to replace him. That causes a lot of resentment ... The burnout is actually increasing here now, [and]... if the situation is not resolved, we are going to have more people burned out and on sick leave because they are just too tired. There is a failing in the system that was supposed to help us.

461 In fact, resentment at increased workloads because of the absence of members on the SPHL was a very common theme among many CF members interviewed by the investigative team. They perceived PTSD as an excuse to avoid work and exit the military with maximum benefits. As one medical health professional put it, "right now all members see is time off and a big pension cheque."

462 Similarly, some regarded PTSD as a convenient excuse to avoid punishment for bad behaviour or to gain benefits others were not entitled to. Other CF members expressed concern that individuals

diagnosed with PTSD are just "malingering," or deliberately feigning the symptoms of a disease to escape duty.

463 Ombudsman's investigators often heard the suspicion that CF members with PTSD "are faking it" for personal gain. One junior army officer told them that, in his view, 75 percent of those diagnosed with PTSD were faking it. However, more than one person pointed out that it would be folly to fake PTSD given the hostility and rejection it creates. A senior Commander advised that anyone who would fake PTSD must indeed have a very serious mental health problem, given the ostracization, stigma and hardship those with PTSD encounter. He was not intending to be humorous.

464 One soldier who continues to perform his job in an exemplary manner although diagnosed with PTSD, repeated some resentful comments he had heard:

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> I am particularly concerned with the attitudes of members in the Forces, particularly my peer group, with regards to people with PTSD. I have heard comments ranging from "Roméo Dallaire was the worst thing that happened to the Forces" to "I bet if you looked at the SPHL or the holding list, every one of them is a below average soldier. They are just faking it. It is a good way to get a pension."

466 Ombudsman's investigators met CF members diagnosed with PTSD who were understandably concerned that they not be tarred with the same brush as members who abuse the system and were just as eager as others that persons abusing the system be identified and disciplined: "If one guy is not telling the truth, then let's not have one bad apple ruin it for everyone else" was a typical response. Or, as another serving member diagnosed with PTSD said, "Let's not create a system where everybody that has a little bit of a problem with the system or who is undisciplined or has a drinking problem can claim he has PTSD because he went to Bosnia 10 years ago."

467 In fact, the danger of widespread abuse of the system appears minimal. Ombudsman's investigators heard from experienced professionals in the medical field that very few patients fake PTSD. One military psychiatrist advised that she had suspicions about only one or two percent of members who presented symptoms of PTSD, and other sources gave similar estimates. Another military psychiatrist emphasized that her patients downplay their symptoms more often than exaggerate them. She believed that those who deny that PTSD exists may themselves have problems they are reluctant to admit to. Another psychiatrist with many years' experience dealing with PTSD expressed the same view. Indeed, investigators heard anecdotal evidence from other sources that some of those most vociferous in denying that PTSD is a genuine illness were subsequently diagnosed with PTSD themselves.

468 Ombudsman's investigators talked to a spouse of a member who had been diagnosed with PTSD who had considerable contact with CF members diagnosed with PTSD and their families. She reflected the frustration that members and their families feel when they are accused of exaggerating their illness for their own gain.

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> That's the whole misconception, "Oh let's get PTSD and make all this money and get out of the military." They don't want to get out of the military. They want their job. They want their life. They want their family. But some can't do that. Ninety percent of them are still working, but that doesn't get printed anyway. There's only about 10 percent that are not able to work. The rest of them are going to work every day and treated like ... They are shunned and they are not given any responsibilities. It's garbage. They are human beings.

470 Nonetheless, Ombudsman's investigators encountered those in the chain of command who believed that it would be possible to fake symptoms of PTSD. The following comment was made by a commissioned officer who had once acted as a supervisor in Cpl McEachern's chain of command:

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> ... you can open a psychology textbook right now and it tells you all the symptoms for post traumatic stress, or any kind of psychological disorder ... and you've got a pretty good chance of convincing them that you've got that disorder.

472 There is little evidence that "faking" is any more prevalent in the CF than in the general population. Ombudsman's investigators contacted the Workplace Safety and Insurance Board (WSIB) in Toronto to ask about the rate of false claims filed by individuals for illness or injury. The Statistics Branch of the WSIB doesn't keep that kind of statistics, but Wayne Pushka, the Assistant Director of the Special Investigations Branch, provided some pertinent information. In fact, it appears that most investigations of false claims are against employers. Of between 2,600 and 3,000 investigations (most against employers) and hundreds of thousands of insurance claims a year, 76 charges were filed against individuals for fraudulent claims in 1998, 127 in 1999, and 135 in 2000. However, these figures do not specify what kind of fraud;

most are for "material change in condition" while "very few" are for faking an injury entirely, according to Mr. Pushka. Mr. Pushka did comment on the false assumptions people have about illness or injury, in that they often assume if a person can't work, they are not capable of any activity (i.e., people call in to report a neighbour mowing the lawn when receiving benefits for not being able to work, without understanding that, just because a person can't do a particular job, it doesn't necessarily rule out other activities).

473 Yet, regardless of the overwhelming evidence that "milking the system" is not a serious issue, the perception that there is widespread malingering related to PTSD remains a significant preoccupation of the military community. This perception was perhaps best summed up in a letter to the *Edmonton Journal* from the wife of a serving soldier, published shortly after the Ombudsman's Office announced this investigation into the complaint by Cpl McEachern. The letter is reproduced below.

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> A soft life awaits soldiers who fake symptoms: Money, maid service among the benefits

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> I am writing in response to an article written in your paper on April 14, entitled "Peacekeepers' Dilemma. Damned if they do, Damned if they don't." I am the wife of a soldier who has served for 16 years. He has seen two operational tours, one to Bosnia and one to Kosovo. I have listened to the stories about post traumatic stress disorder (PTSD) in the military and have remained silent. I find that I can no longer do that. I am not trying to negate the fact that some soldiers saw horrible things on tour. I can't even begin to imagine. I will not debate if PTSD really exists or if it is a product of modern culture. I am not a psychologist.

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> I will admit to being one of the people that harbours some resentment and disgust when I hear yet another story of a soldier that suffers from this elusive disorder. Dr. Wendy White, clinical director of the Operational Trauma and Stress Support Centre, asks the question herself in your article: why would a soldier fake PTSD?

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> She's right; they do face contempt from their peers. However she makes it seem very unlikely for someone to fake it. I beg to differ. There is one very large issue that your article forgets to mention and it is one of the biggest reasons that someone might fake this disorder

— money. Claiming PTSD is tapping into a huge cash cow. We sit back and watch some claim they have PTSD and suddenly Veterans Affairs kicks in money — lots of money — and services. So, here sits this soldier, receiving regular military pay plus medical pay and sometimes even maid service from the Veterans Affairs office. And some soldiers are given medical leave for up to two years That is a holiday — with pay — for two years.

478 In that time my husband has been away from his family for 14 months. Am I a little bitter? You bet I am!

479 According to the military first aid book, written in conjunction with St. John Ambulance and the Department of National Defence, "The key to helping a stress casualty (PTSD) is keeping him close enough to the sounds and action of the front so that he does not break contact with his unit, with his job and with his dignity."

480 So, time off is not a solution, it only adds to the problem. A soldier could be given a garrison job that he or she can function in, not left to dwell on emotional problems without a sense of purpose. This would serve to alleviate some of the resentment from their peers while giving the soldier a sense of still belonging.

481 Let's not forget to mention the fact that when soldiers are unfit for regular duty, the remaining soldiers must pick up the slack. Duties increase, along with time away from home, and pressure to continue short-handed. Do you not think that that alone would cause resentment, frustration and anger? Why do you only hear about the soldier with PTSD? What about medical services personnel, ambulance drivers, doctors, fire-fighters, and police officers? People who deal with life and death on a day-to-day basis? The new kinder and gentler army has soldiers almost convinced that they have PTSD before they even leave for a tour.

482 Because of the media fascination with this subject, the soldiers are almost convinced that they should have it. Self-fulfilling prophecy for some? Maybe. Maybe it is time for more intensive screening for those claiming that they are suffering. Maybe the purse strings need

> to be tightened in order to discourage those that are jumping at the money. It is medical services, not money that will help these people recover.

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> It is the soldiers that are faking PTSD that are causing the mistrust and resentment for the rest. Nobody could leave a place like Bosnia and Kosovo and not carry scars. I am certain that there are men and women that have PTSD or "normal reactions to human suffering." I also believe that there are those who are faking it.[10]

484 This letter created considerable reaction in the military community. Significantly, many individuals in the chain of command at LFWA, including the CO at the time, expressed dismay about its contents to the Ombudsman's Special Advisor on PTSD; they found significant flaws in the author's viewpoint. A soldier diagnosed with PTSD, having read the letter, summed up his feelings as follows:

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> Thanks. I am going to kill myself now, because I am nothing more than a waste of rations and a burden on the system. I am not a human being deserving the same kind of compassion and understanding that her hard-working husband does.

486 In my view, many of the opinions expressed in the letter appear to be based on ignorance about PTSD and how it is best treated. Unfortunately, Ombudsman's investigators heard of instances in which the chain of command did little to dispel these attitudes. A senior NCM told them that, when he raised the subject of PTSD with a Captain in his unit, the Captain commented, "This is a bunch of bullshit. These guys are assholes. They are out there screwing the system and they have civilian jobs." In another region of the country, a senior NCM with 25 years of experience in the medical field told my investigators, "Some people do certainly regard it [PTSD] as a way of people getting out of work. Sometimes there is not a lot of compassion for these people."

487 Ombudsman's investigators heard from caregivers that work therapy can be an important part of the recovery process (as discussed under Treatment in Part Two of this report). In some cases, caregivers recommend that members on the SPHL who are likely to be released get work as part of the transition process to civilian life; most often, individuals are placed on educational or vocational courses to prepare them for release. These members' symptoms are such that they are not mentally capable of working in a military environment. In a few instances, members are encouraged to work as part of the rehabilitation process.

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[10] *Edmonton Journal*. 18 April 2001, page A17.

488 Frequently in the course of this investigation, military members expressed strong resentment that some soldiers were working in civilian jobs while on the SPHL. They appear to believe that soldiers well enough to work downtown should be working in the unit. As a senior NCM commented:

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> What some of these soldiers are doing on SPHL, is that they don't come to work on SPHL. They stay at home. They do whatever they feel they want to do. If they don't feel like going in, they'll just phone somebody up and say, "I don't feel too good today, I'm not coming in." And then they'll go to work downtown ... [and] I will tell you something, from a soldierly level, that's a major issue because soldiers are soldiers. They don't want to see someone get something for nothing. They feel sorry for the individual for the situation he's in and they hope that he gets help, but for God's sake we can't be allowing somebody to draw $45,000 a year to sit at home and watch TV and draw $45,000 from the military and then go to work downtown as a bouncer or go run your own business during the day ... If they get paid to do nothing then go to work somewhere else, then that's insane. It's a bone of contention at the soldier level because they know it is going on. They see these guys.

490 Another very senior NCM commented:

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> ... they [soldiers] can't understand that we have individuals on these lists [SPHL] for post traumatic stress disorder who cannot work in a military capacity, yet they can work in any other capacity — they can get another job downtown. Soldiers don't understand that. It is almost like welfare fraud. It is almost like unemployment cheats.

492 In one unit in Edmonton, the chain of command asked for a National Investigative Service (NIS) investigation of a soldier's outside work activity because of suspicions he was faking inability to work. The soldier had been diagnosed and was under treatment for PTSD. The soldier had a hobby that he had developed into a small-business venture, although he made no net profit from the business. The clinical social worker who was treating him for PTSD while he was on stress leave encouraged him to develop this business. She judged it to be therapeutically beneficial for him to be involved in an activity that would prevent him from dwelling on his condition and increase his self-confidence and social interaction. The soldier had already sought and received approval from his CO to pursue this venture. However, a new CO and WO subsequently tasked the MP to investigate the business activity. The NIS then subjected the soldier to surveillance, at his home and place of business. He was told that if he wished to come onto the base, he would have to report to the office and obtain a visitor's pass. After many complaints by the soldier, the investigation was ceased and the soldier received a letter of apology from the new CO, indicating that he had not read the soldier's Personnel file and thus was unaware that permission had been granted for the business venture.

493 Cpl McEachern's former Platoon Commander commented that some perceive soldiers who work while on the SPHL as faking PTSD and resent them enjoying what is perceived to be the good life on the SPHL.

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> People are smart and I do know people have abused the system in other ways. People have submitted fraudulent claims. They have lied to get overseas on tour. So what is stopping people [from faking it]?

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> You compound that with the fact that people are on the same tour as another guy and on that tour nothing happens or they know specifically that person was never involved in an incident, yet he is being diagnosed as having post traumatic stress disorder. People's wheels start turning.

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> Then you add to the fact that people are working jobs. They are out living their lives in a social environment, drinking and spending all this money that they have gotten from the military because they are paying them while they are on stress leave. Yes, resentment is going to develop.

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> My concern is that the people who really, really have it, there is going to be an aura developing right now that they are scamming the system. It's one thing to be on stress leave to be going to counselling and maybe you are at home ... When a guy is living his life normally, day to day, and flaunting it in front of other people, people question: "What's wrong with this guy? I thought he was a stress victim."

498 One psychiatrist interviewed by Ombudsman's investigators explained the negative reaction of many military personnel as a way of distancing themselves from the prospect of PTSD:

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> From a psychiatric point of view, what they are doing is they find fault with the person in order to distance themselves and say, "that would never happen to me." That is basically what is going on. Sometimes I have a little trouble remembering that.

500 Apparently, those with more experience in the field tend to be more understanding of and sympathetic to members with PTSD, since they recognize that it could happen to them ("there, but for the grace of God, go I"). It was suggested that younger, less experienced CF members — those most influenced by the traditional macho image of what constitutes a good soldier — tend to be hardest on those with PTSD. It was also suggested that infantry personnel were intolerant of any injury, including psychological illness, even among their peers. As one Master Corporal stated:

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> In the infantry, the analogy I would use is that it is like running with a wolf pack. It's fine when you are running with the pack. The minute you start bleeding or limping then they are on you, 'them' being the command, the higher ups, the NCMs.

502 Interviews with representatives from foreign militaries confirmed that resentment toward members with PTSD by their peers, who believe they are abusing the system, is a problem in those agencies as well.

Impact of shortage of personnel

503 In a climate of personnel shortages, there is resentment toward those who cannot carry their full load, particularly if their illness is not physically visible — as frequently stated, blood tests or X-rays cannot prove the disorder exists. Accordingly, there is a widespread feeling in the CF that those with stress-related illnesses are "malingering." This attitude increases the feelings of shame for many soldiers with PTSD, who naturally tend to feel guilty for letting the team down.

504 The shortage of personnel at the unit level exacerbates the stigma associated with stress-related injuries, owing to resentment at the

increased workload experienced by those who remain in the unit unless replacements are available.

505 As discussed in detail earlier in this section, we found that, by and large, sick soldiers, as well as the unit and the CF as a whole, benefit by keeping those with PTSD as close to their unit as possible; they should be placed on the SPHL only as a last resort. Many individuals interviewed by investigators suggested that resentment toward individuals on the SPHL could be somewhat alleviated if they could remain in the unit doing "light duties" that did not count against the unit's allocation of human resources. In other words, individuals diagnosed with PTSD should be allowed to remain with the unit and continue to contribute to the unit, but a replacement be allocated. As one individual commented, this approach:

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> … takes that away as an excuse for being negative. It doesn't remove the frustration because I still have to find a Class C. I still have to go through the replacement. I have to train them. They are not as familiar, but at least I have an individual. If I could also keep the individual with PTSD in the unit, maybe they are only working part time, maybe they are only working one day out of the week, but I am not losing them completely and I have an extra person in to help.

507 This Office is concerned by reports that workloads are so heavy that unit members are simply too busy to maintain meaningful contact with members on the SPHL. Perhaps it is understandable that units already short-staffed and over-burdened neglect to maintain contact with members on the SPHL, but it is not acceptable.

Reluctance of members to seek help

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> Perhaps the hardest thing is to convince guys to come forward. If you can make it as easy as possible for guys to come forward, then you can get them on the road to recovery.
>
> CF member

509 Many members with symptoms of PTSD are reluctant to seek treatment because they have lost trust in the CF. It is evident from this investigation that early diagnosis and treatment of individuals suffering from PTSD is a critical component in the success of treatment. To encourage early detection and intervention, it is essential that all CF members understand and recognize the symptoms of PTSD; it is just as important that members have confidence in the CF, particularly in their chain of command and peer group, to treat them sympathetically and with respect.

510 Fear of disclosing symptoms of PTSD is pervasive in the CF. Soldiers are keenly aware of what has happened to colleagues diagnosed with PTSD and most are not encouraged by what they observed. In fact, Ombudsman's investigators spoke to numerous CF members who indicated that they had stress-related problems, but hesitated to seek assistance because of their distrust of the system based on how they'd seen others treated. As one soldier put it:

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> If I walk up to someone and say, "I have PTSD" or "I think I am really stressed out. I am having a hard time with things," the next thing you know you are in the office and you are taken away from your parent unit. You are gone to Halifax. They are giving you medication. They are talking to you with white jackets on. The next thing that happens is that you are on the way out of the door of the Army. Who feeds your kids? Who pays your rent? Who makes sure your kids go to college? Nobody wants that. They are going to fight like hell to stay in, and they are going to dodge every hospital that comes to them. I will bet you that there are a lot of people right now who are doing exactly like I said … Nobody wants to come forward and say, "Look, I'm hurting." There are a lot of guys out there hurting and they won't come forward. They are not going to get treated because they won't come forward.

512 A member who is being successfully treated for PTSD told us that he has not told his peers he is being treated for PTSD because he feels "his working days as a [soldier] would then be over." He cited comments by peers about soldiers with PTSD as the reason for his reluctance, comments such as, "PTSD is a get out of jail free card."

513 A senior caregiver noted the relationship between prevailing attitudes and the lack of encouragement from the chain of command for members with symptoms of PTSD to seek treatment:

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> Whether they realize it or not, the message that these leaders send out is a profound deterrent to subordinates identifying a problem and coming forward for help. For example, although social workers, psychologists and mental health nurses have no authority and do not grant sick leave for stress, we

> are derided for granting it — there's nothing better to discourage a member from coming forward with a stress-related injury than to hear his/her CPO deriding members who are granted sick leave for stress and the helping professions who grant it. 'Stress leave' is used by these people with the same negative connotation as 'politically correct,' with the attendant message that it is a detriment to the CF/mission/good order and discipline, etc. to be avoided lest you show yourself to be less than 100 percent loyal and dedicated.

515 The majority of soldiers to whom investigators spoke believe that the CF prefers to release soldiers with medical problems quickly rather than try to help them recover, and that the Universality of Service principle requires they be able to deploy or leave the service. According to one soldier, when he sought help from an Area Social Worker he was told that, if he requested stress leave, it would mean the end of his career. On his return from stress leave, his WO described him as one of the "sick, lame and lazy." Whether intentionally or not, the CF has created an impression of the "throw-away" soldier, in the minds of virtually every soldier Ombudsman's investigators spoke to — if you are broken you are discarded. The CF is well aware of this issue, as outlined in the 2001 *CDS Guidance to Commanding Officers*:

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> The ... attitude is that mental illness is somehow voluntary, and is a sign of personal weakness or lack of moral fibre. This causes people with mental illness to sometimes conceal their symptoms, and not seek appropriate help. In the military context, there is also the concern that diagnosis could lead to career repercussions. Accessing treatment can be seen as a gamble ... Unfortunately, the stigma associated with mental illness is still causing some CF members to delay accessing treatment.

517 According to a senior NCM interviewed by investigators:

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> There probably isn't a unit in the Armed Forces right now that has not got one of its own horror stories that the troops can relate to where they have seen one of their peers or their supervisors, be it a senior NCM or an officer or a young troop, that has been raked over the coals because he came forward with PTSD problems. [They] have witnessed that troop being humiliated, cut off, blackballed, whatever you want to call it, within that unit by that chain of command ... [These] troops have seen the humiliation that a friend has gone through within their organization. Be it a

> friend or not, the fact that they have witnessed him being mocked within their system, you have created an atmosphere of distrust. Some of that distrust was created by people in positions of leadership by not taking the guy's concerns as real, by the leadership saying that "this guy's a loony-bin," and by administrative problems ... They have seen that so you have created the distrust in the system. Poor leadership has created the distrust.

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> Those troops are reluctant to come forward and they are probably scared the same thing is going to happen to them ... [All] of these units have horror stories where they have seen people within their unit, highly respected people in some cases, be all of a sudden left out to dry because they were having medical problems related to a mental illness.

520 Members' reluctance to seek treatment, often for years, often appears to be justified. As one soldier said:

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> I can't tell anyone because, first of all it's shameful. It's a sign of weakness. It wasn't going to be accepted. I knew it wasn't going to be accepted as an illness [by] any of my colleagues.

522 Aside from the fear of losing one's career, members are reluctant to accept that they may have a mental illness. In the population at large, as well as in the CF, the stigma attached to mental illness makes acceptance difficult, as previously discussed in this report.

523 One soldier, who told investigators about inadvertently stepping on the faces of dead children during a rescue operation, confessed he cannot bring himself to admit he has an illness; he wondered "if I am just a coward?" His view is not unusual. Many CF members simply cannot conceive they might have a mental illness; members in the combat arms, and especially rifle companies, are especially reluctant to acknowledge that something might be wrong. As one senior NCM told us, "Nobody fucked with me, and here I was having a mental health problem. Soldiers aren't supposed to have that."

524 Many members who had been diagnosed with PTSD told investigators of months or years during which their symptoms increased in severity, including substance abuse, decreased job performance and inability to control emotions, particularly anger. Several described suicide attempts. Not until a spouse or, sometimes, their children issued an ultimatum did they seek treatment. Caregivers that investigators spoke to confirmed the extreme reluctance. One experienced MFRC executive confirmed that PTSD sufferers "don't look for help until the wife's walking out of the door with the kids." The following quote from a soldier is illustrative:

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> Why I went and got help in the first place is that I came home from work and I sat on the step. I had so many of these attacks, I didn't know what was going on. I just sat there and broke down and started crying. My little girl came up to me and she put her arms around me and she said, "Daddy, it's going to be OK." I looked at her right there and then and I said, "I don't care. The military don't mean nothing to me. I'm going to get help because of this." Because she needs a daddy.

Lack of trust in the CF

526 Members who resist coming forward for help with symptoms of PTSD clearly lack trust in the CF; others' trust is damaged by their perceptions of how those who have come forward are treated by the organization. Cpl McEachern's statement of loss of faith, below, from his interview with Ombudsman's investigators, is shared by many others diagnosed with PTSD:

527

> You have to understand how fried these guys are ... I have talked to people who I know, but everybody is just so fed up with the whole system that they just want to get out of the Army and go home. They don't want anything to do with anybody. I don't know how much good you are going to get out of this with just me coming forward because everybody is just scared. They are scared of losing their jobs. They are scared of how they are going to support their families. They are scared about how they are going to adjust back to civilian life now that they have been suffering through PTSD. They are humiliated and abandoned by the regiment. The regimental system is there to help soldiers through war. The whole regimental system is based on support and the family environment for its soldiers going through difficult times. A lot of times when the soldiers come out of the difficult environments, that is what they fall [back] on, the regimental system, the regimental honour, the flags, the guys who died for the flags, the honour. "Okay, we know you're sick. We are going to take care of you." None of that is there. There is no sense of regimental

> family at all any more. It is all everyone out for himself and get out with what you can.

528 Investigators noted the sense of bitterness, anger and betrayal among members with PTSD over the way they felt the CF had treated them, particularly among members of regiments in whom the notion of a 'regimental family' that would look after its own through thick and thin had been inculcated.

529 As noted elsewhere in this report, the majority of members diagnosed with PTSD were considered above-average soldiers, deeply committed to their careers. They were also particularly committed to their units. The lack of trust they expressed toward the CF tended to focus on the unit, as opposed to the caregiving system.

Summary and recommendation

530 To conclude, improving negative attitudes about PTSD is a leadership issue at all levels. One of the most fundamental principles and priorities of military leadership is the welfare of the troops. The 2001 *CDS Guidance to Commanding Officers* recognizes the role of leaders in creating and fostering positive attitudes to those with mental illnesses:

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> The first issue is the need to create a culture in which people suffering from mental illness feel safe in accessing health care, and are also encouraged and supported in returning to full functioning. CF members require a 'can do' attitude, and a degree of mental toughness to perform their tasks. However, it must be understood that mental illness (as distinct from misbehaviour) is not indicative of a lack of resolve, or a lack of mental toughness. Mental illness is a problem, which, if corrected, will return a soldier to his former level of functioning. One step in the solution is creating a culture where unit members are educated about the effects of stress and the symptoms of mental illness, and in which it is made clear that the best way to deal with this type of problem is to attack it head on and bring into play all available resources to bring about its resolution. COs can play a key role in encouraging this type of culture within a unit.

532 In the CF today, ensuring that every individual in the chain of command understands PTSD and recognizes how to deal with it is a major leadership challenge.

533 There appears to be a concern in some quarters that acknowledging or dealing with PTSD will somehow exacerbate the situation. In many interactions with CF members at all ranks, Ombudsman's investigators detected a sense that talking about PTSD would actually increase the incidence of the disorder. One member of the chain of command suggested the people who are talking about PTSD and asking questions about it are actually increasing the prevalence of PTSD in the system. Or, as a senior NCM would have it, "I think what has happened to us in the military over the years is that we are looking for problems. We are forcing these problems on the soldiers."

534 Avoiding a medical problem that has been around for centuries because of a fear of somehow creating or spreading PTSD among CF members is not a viable or desirable course of action. It presumes that CF members are not capable of dealing with the truth about PTSD, and underestimates the capability of the men and women of the CF. I am not aware of any evidence that educating members about PTSD will lead to increased incidence of the disorder and educating members will encourage those who may be reluctant to access help to come forward. Ignoring the issue and hoping it will go away hurts individuals with PTSD and is ultimately detrimental to the CF. In my view, burying one's head in the sand is a potentially disastrous approach to a manageable problem.

535 Finally, it is important to contradict the fairly widespread attitude in some quarters that members with PTSD are weak individuals, without the necessary toughness to make good soldiers. Nothing could be further from the truth. As noted elsewhere in this report, most of the soldiers encountered in the course of this investigation, including Cpl McEachern, were assessed as good to excellent soldiers. A former CF psychiatrist put it this way:

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> As a closing statement — it's sort of interesting because I have done a lot of work over the years with people with PTSD. If you asked me who would I take on tour with me, who would I trust to do the job, it would be most of the patients I have dealt with. I know they can do the job. The difficulty is the cost when they come home. PTSD doesn't keep you necessarily from doing your job as a soldier. Some of these guys are the best soldiers you will ever see. What

> PTSD does, though, is it exacts such a cost when you come home to your family, to your friends, and to be a Canadian again. That's the problem. But if you asked me who would I trust to guard me — I have a handful of people I would pick for a platoon and do you know what? Just about all of them would have PTSD ... I have been around almost 22 years in the military. I have been around a lot of time on the army side. I have been around a lot of soldiers. There are a lot of people I have respect for. But the people I truly trust are some of the people I have treated, some of the people within the PTSD group, because I know they would do the job. I know they would take care of me. But it would be such a cost when we came back home that I would never ask that from them.

537 The system has an obligation to create and foster an environment in which members with PTSD can recover as quickly as possible. That duty begins with changing attitudes at the member's own unit. While such cultural change is difficult to achieve, it is not impossible; for example, to its credit, the CF has tackled gender and harassment issues aggressively, with some encouraging results.

538 In summary, reluctance to seek treatment is a serious issue because the sooner members get the help they need, the more likely they are to return to productive work. As mentioned elsewhere in this report, at least one military psychiatrist estimates that, for every CF member diagnosed with PTSD, there are perhaps up to five others with symptoms who do not seek assistance. While it is not clear how many do not come forward because they don't acknowledge they are sick, it is quite clear that many more refuse the help they need because of concerns for the consequences to their careers.

539 The issue of resentment toward outside income cannot be ignored, even though to our knowledge relatively few members are fit enough to obtain gainful employment while being treated for PTSD. This type of resentment feeds into the myth of malingering with PTSD in a very damaging way.

540 One possible solution is as follows: in situations in which a CF member is unable to perform his or her duties by virtue of a medical diagnosis, and where the treating physician or mental health caregiver has determined that occupational activity would be therapeutic, that soldier may engage in paid employment on condition that any salary or other income obtained is deducted from his or her CF salary. This solution was proposed to several parties, including the soldier mentioned above, who started his own business. He had no objection, as such a solution might alleviate the perceptions of "double dipping." I recognize, however, that a definite solution to the problems raised here should take into account many other considerations and implications. Therefore, I believe that this is an area that is worthy of further study by the appropriate authority at NDHQ.

541 I therefore recommend that:

4. **The CF examine the issue of work therapy while on the SPHL in more detail, with a view to creating policies and procedures to deal equitably with issues that arise from members on the SPHL earning secondary income from employment as part of a therapy program.**

542 To summarize, Ombudsman's investigators found attitudes toward PTSD in the CF confirm much of Cpl McEachern's assessment. There is a widespread ignorance and lack of sympathy about PTSD within the culture of the CF as a whole. Not surprisingly, these attitudes created an environment that exacerbated Cpl McEachern's illness, minimizing his chances of returning to the soldiering he loved. Many other current and former CF members investigators interviewed during the course of this investigation shared Cpl McEachern's perceptions and echoed his views.

543 It is not news that much needs to be done to change attitudes about PTSD within the CF. The Croatia BOI reached the same conclusion. It found that, "In general, CF members are poorly informed about mental health issues and the link between physical and mental health," and noted "an appalling lack of knowledge about mental health by CF members at all rank levels." The BOI also noted that mental health education "should be mandatory on all leadership courses to counter ill-informed attitudes. This education must begin at the leadership level." The BOI recommended that the CF change "attitudes and improve procedures across the Canadian Forces on mental and physical health issues and programs." The action initially recommended, which was to expand, develop and refine course programs for target areas, was supposed to be completed by 15 September 2001. However, the most recent status report on the implementation of the recommendations dated 13 July 2001 indicates that "revision to common qualification standards and course training plans are ongoing, but full implementation will not occur before 2002."

Part Four:

General education and training about PTSD

544 Education is the single most important catalyst to change attitudes about PTSD in the CF. Without co-ordinated education and training programs designed to ensure all members understand what PTSD is, it will be impossible to change entrenched attitudes. Orders from above, exclusive reliance on CANFORGENs or application of the Code of Service Discipline cannot in themselves change attitudes, although I am of the view that any proven case of harassment or discrimination against those with PTSD should be dealt with harshly.

545 The CF has faced similar challenges in the recent past with considerable success. It is tackling both gender integration and sexual harassment with a combination of clear, committed leadership and a mandatory education and training program. In my view, the CF should exercise a similar approach to deal with issues related to PTSD.

546 Cpl McEachern stated that the only education or training he received about PTSD during his entire career was a five-minute debriefing in 1994. While some improvements have been made since that time, particularly in deployment-related training, much remains to be done.

547 Ombudsman's investigators examined education and training from three perspectives. First, they examined what CF members are taught about PTSD in a general context, regardless of whether members are deployed, from the moment members join up until the day members retire. General education and training about PTSD is discussed first in this part. Second, they looked at additional education and training provided to deployed CF members, before, during and after deployment. Deployment-related training and procedures are discussed in Part Five. Third, they examined the issue of education provided to caregivers (Part Six), an issue that arose during the course of the investigation.

Investigating CF education and training about PTSD

548 As a starting point, Ombudsman's investigators asked Cpl McEachern for his opinion on education and training about PTSD in the CF. He told them:

> **549** Education needs to start at every basic level within the Army. It needs to be addressed through basic training. It needs to be addressed more seriously for any leadership courses that are going through. Right now, on leadership courses, you will get kind of about a 40-minute, one-lesson blurb on PTSD and other medical problems that are common within the combat arms. It is just kind of all grouped together as one.
>
> **550** Like I said, the stigma that is attached to it is that it is a weakness and that it is a big joke and everybody kind of laughs, and da-dee-da-dee-da. It needs to be taken a professional approach to, like the police departments do. How you are going to change the — what is the word I am looking for? — the environment or the mentality? That is up to the units.
>
> **551** I think it needs to accompany the training throughout a soldier's career. It shouldn't be just a 40-minute class some day while he is doing his leadership course. To everyone, that is just an opportunity for a smoke break.
>
> **552** We are not playing in Cyprus any more. I don't know what the environment is like over there now. I can't speak to that. It needs to be addressed that there is a percentage of people who have it. We are not training here. Some of the stuff is real.
>
> **553** Unfortunately, right now, it takes time to incorporate any changes into the system … It is a tough call. I just think it needs to be included and taken more seriously throughout the training.

554 His views were echoed by many others at all levels within the CF.

555 The investigative team looked at:

556
- current education and training provided to CF members about PTSD and issues related to PTSD, including education

delivered at CF educational establishments, training provided to caregivers and deployment-related training;

- 557 the importance of education and training as an agent of cultural change and for identifying PTSD issues at the earliest possible juncture;
- 558 education and training in other organizations;
- 559 effective delivery methods; and
- 560 CF communications initiatives directed to both caregivers and members in general.

Current training provided

561 The investigative team contacted a large number of educational and training establishments and organizations throughout the CF, including the CF Recruiting, Education and Training System (CFRETS), Royal Military College (RMC), the CF Leadership and Recruit School (CFLRS) St-Jean, and the CF College (CFC), as well as the battle schools at the WATC and Gagetown. Investigators also contacted several field units to determine what training, if any, was given on a unit-by-unit basis. They were particularly interested in ascertaining at what points in a member's career is training about PTSD and related issues given; the content of any training; and who delivered the training.

Canadian Forces Recruiting, Education and Training System (CFRETS)

562 CFRETS has a mandate to support the operational capability of the CF/DND through the recruitment, education and individual training[11] of CF members. CFRETS is responsible for recruiting, education, general-purpose individual training and individual training for occupations common to more than one military environment.

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[11] Individual training and training that is common to all the environments (Army, Navy, Air Force) is the responsibility of the central training system — CFRETS. Collective training and/or operational training are the responsibility of the individual environments.

563 CFRETS headquarters is located at CFB Borden in Ontario and comprises: RMC in Kingston, Ontario; the CFC in Toronto; the Canadian Forces Support Training Group (CFSTG), including CFB Borden; the Canadian Forces Recruiting Group (CFRG) at CFB Borden; and the Regional Cadet Organization (RCO) at CFB Borden. CFRETS oversees training and education in the CF. Altogether, there are 20 schools and units under its aegis, 10 of which are located at CFB Borden.

564 The investigative team contacted CFRETS to ascertain what training had been developed to educate members about PTSD. CFRETS advised that "signs and symptoms of PTSD" have been identified as a knowledge requirement for both officers and NCMs. The topic is, or will be, included in most qualification standards and, when applicable, in the training plans of all ranks from Private to Colonel.

565 The investigative team obtained and reviewed copies of training schedules on PTSD developed by CFRETS. These schedules provide an overview of the points in a member's career at which he or she will receive education about PTSD or related issues. Delivery, and the format in which the education is delivered, is the responsibility of those who conduct the courses. The investigative team concluded that considerable work needs to be done to improve education about PTSD; for example, Ombudsman's investigators were advised that detailed training plans have yet to be developed for senior officers and senior NCMs.

566 A senior officer from CFRETS advised that delays in implementing training plans in the field are the result of resource constraints and the reluctance of some training establishments to modify their training. Anecdotal evidence indicates that demands on training establishments are increasing, while time and resources are either static or decreasing. Several training establishments advised that they simply did not have the time to include anything on the topic of PTSD. One training school Commander lamented, "Too much curriculum, too little time," a sentiment echoed throughout the training system.

Royal Military College (RMC)

567 The investigative team was advised that RMC does not provide any significant education or training about PTSD in any of its courses. PTSD is briefly discussed, in theory, in a course on military psychology and combat offered by the Department of Military

Psychology and Leadership. The course is not mandatory, and is taken by approximately 10 percent of students.

Canadian Forces Leadership and Recruit School (CFLRS) St-Jean

568 Investigators contacted CFLRS St-Jean, which is responsible for basic officer and NCM training, as well as some NCM leadership training. They spoke to instructors for each of the following courses:

569
- Basic Officer Training (BOTC) — The newly developed Enhanced Leadership Model (ELM) course will include stress-related training, including a component on "signs and symptoms of PTSD." There appears to have been little significant training about PTSD previously.

570
- Basic Military Qualification (BMQ) — As of 3 July 2001 the BMQ course, which is for new NCMs, has included four 40-minute periods on stress. The topics studied include: types of critical incident stress (CIS), PTSD, stress management, and recognizing suicide risks. The unit nurse delivers the training. Prior to 3 July 2001, the only training about PTSD was delivered by the padre, who may have touched on stress-related issues in the four periods with recruits allotted to the padre.

571
- Senior Leadership Academy — The senior leadership academy conducts an Intermediate Leadership Qualification course for members being promoted to the rank of Warrant Officer. At present, two periods during the course are dedicated to "operational stress."

Canadian Forces Military Police Academy (CFMPA)

572 The CFMPA is particularly proactive in dealing with the issue of PTSD. It provides two formal 50-minute lectures on PTSD for both the Basic Military Police Qualification Level 3 and the Basic Military Police courses. Social workers and/or MOs deliver the lectures.

573 The CFMPA also provides ongoing training about PTSD in other courses it provides, including journeyman-, supervisor- and manager-level courses. Although issues related to PTSD do not constitute a separate topic on these courses, the topic is included in other lessons on leadership, personnel administration, etc. The training is delivered through a variety of methods, from self-learning packages to presentations by guest lecturers.

574 Investigators reviewed some learning materials provided by the CFMPA and found that, while the focus appears to be on CIS, much of the material provides a solid foundation for introducing PTSD.

Canadian Forces Chaplain School and Centre (CFChSC)

575 Military padres are on the front lines in dealing with PTSD both within deployed units and in garrisons. The school offers considerable instruction relating to PTSD as part of the chaplain BOTC. Two specific courses deal with stress-related issues: the Combat Stress Reaction (CSR) course has four periods of instruction, 160 minutes in total, presented by subject matter experts from the National Defence Medical Centre (NDMC). The course on Psychological Casualties of Military Operations has eight periods of instruction, 320 minutes in total, also presented by NDMC experts. This course specifically includes PTSD and discusses criteria for recognition, treatment and prevention of PTSD.

Canadian Forces Fire Academy (CFFA)

576 The CFFA provides training at the management level. The commandant advised that most CF fire halls have in-house training and support systems relating to operational stress.

Other CFB Borden schools

577 Ombudsman's investigators contacted several of the trade schools at CFB Borden. Other than the medical school, none offer any significant training about PTSD as part of the curricula, nor is it in their mandate to do so.

Canadian Forces College (CFC)

578 CFC provides a 10-and-a-half-month command and staff course at the Major/Lieutenant-Commander level. Most candidates are promoted either during or after the course. This course has a three-hour component on combat stress that touches on PTSD, delivered by a medical doctor from the Defence and Civil Institute for Environmental Medicine (DCIEM). Apparently, LGen Dallaire was recently invited to speak to course candidates about his experiences. As head of a small force of UN peacekeepers during Rwanda's civil war in 1994, LGen Dallaire suffered PTSD after witnessing the massacre of over 800,000 Rwandans in the space of a few days. Although he warned superiors of the impending horror, he was prevented from intervening. Recently retired, LGen Dallaire is one of the most vocal military personnel to bring this disorder to public attention. He remains a strong proponent of reform of the CF mental health system and also spearheaded the reform of leadership training and development in the CF officer corps.

579 CFC also provides various courses for senior officers including generals; investigators were advised that nothing is formally taught about PTSD in any of these courses.

Canadian Land Forces Staff College (CLFSC)

580 CLFSC provides two courses. The first, the Transitional Command and Staff course, is designed for senior Captains and junior Majors; no training about PTSD is delivered in the course. The second course held at CLFSC is the CO course, a two-week course for officers taking command of a unit, up to and including brigade level. It has no formal PTSD component, but does include the occasional guest speaker on "force health issues."

Canadian Forces School of Aerospace Studies (CFSAS)

581 At present, the Air Force Professional Military Education courses do not touch on the subject of PTSD. Prior to 1997, the old Air Force Staff course used to have a guest lecturer talk about CIS and other stress-related topics, but this component was deleted with the transition to the Basic Aerospace Operations course and the Advanced Aerospace Operations course.

Battle schools

582 Ombudsman's investigators contacted the WATC in Wainwright, Alberta, to ascertain what their trainers, charged with preparing CF members for combat, are taught about PTSD and stress-related issues. They also contacted the Combat Training Centre (CTC) in Gagetown, New Brunswick.

583 WATC appears to be taking a proactive approach to PTSD and other stress-related issues with the support of the chain of command. Present programs include stress management, anger management and suicide intervention. WATC anticipates conducting PTSD briefings in the fall, using OTSSC staff.

584 Ombudsman's investigators spoke with a caregiver at WATC, who currently delivers a portion of the PTSD training for instructors posted to WATC. Her written response to their questions provides a description of the programs:

585

> Regarding PTSD/CIS education we are in what you could call the infancy stages. In April this year we ran a trial on a small group of trainers to see if it would be received favourably. Based on the results we are now going to place it in the fall IST package given to trainers. This brief was given by [OTSSC staff] and focused on education on these particular subjects. It is offered to both military and civilians. In particular we try to target the trainers but it is difficult, as most are busy training. You can get placed on the list simply by submitting your name through your respective chain of command. The same applies for Suicide Intervention and the 1/2-day anger management 1/2-day stress awareness. Last year was the start year for all our programs and we ran 2 of each with full attendance or close to for all. We try to organize around the WATC training schedule to ensure maximum attendance of the trainers but this is difficult.

586 A Personnel Selection Officer (PSO) referred to investigators as CTC's expert on these issues, advised that several initiatives are under way to train peer counsellors (also called 'peer defusers'). However, nothing is mandated in course programs on PTSD, although training is given on an *ad hoc* basis at the request of individual COs.

Peacekeeping Support Training Centre (PSTC)

587 PSTC provides two courses. The Peacekeeping Support Operations basic course prepares CF members of all ranks deploying as individual augmentees/reinforcements on peacekeeping missions. The Military Observer Course is designed for CF members about to deploy as observers or be placed on the International Standby List for unforecast missions.

588 Candidates on both courses receive stress management training from subject matter experts from NDHQ or CFB Kingston. The training includes the video *Witness to Evil*, which is about what happened in Rwanda, and discusses types of stress, including PTSD.

589 PSTC advised Ombudsman's investigators that, although it does assist in preparing formed contingents that rotate into theatres of operations, it does not have the expertise to present stress-related training. Recently, a PSTC staff member participated in a half-day course in CIS management delivered to all members of 2 PPCLI.

Unit training initiatives

590 In general, there have recently been significant improvements in both the quality and quantity of training and education related to PTSD within individual units Ombudsman's investigators contacted; for example, every member of 2 PPCLI recently took a half-day CIS management course, and other units may be offering similar initiatives. There are two main reasons for the improvements: increased awareness of the issue within the chain of command, and a dedicated and effective outreach effort by many OTSSCs to educate members. OTSSC staff members have been invited to make presentations at unit professional development days and other forums; this appears to be a cost-effective and efficient way of imparting knowledge about PTSD on a unit-by-unit basis.

591 In addition, soldiers are increasingly being trained in peer support. Certain members of units of all ranks are identified on the basis of their leadership skills and empathy. They are trained to recognize stress-related symptoms in others and to provide assistance to such members as early as possible.

592 Peer support training varies from area to area. In Winnipeg, 2 PPCLI recently held a two-day peer defuser training course conducted by OTSSC staff from Edmonton and the 17 Wing social worker. The battalion trained over 100 peer defusers of all ranks. Part of the objective was to spread a cadre of individuals in a position to help throughout the unit.

593 Peer support is a valuable tool, but it is by no means a panacea. It is a "step in the right direction," as one senior NCM said, but is

only one of the tools the CF requires to educate and train its members about PTSD and stress-related issues.

The importance of education and training about PTSD

594 Educating CF members about PTSD has a twofold purpose. First, by enabling members to understand PTSD, education does much to demystify and destigmatize the disorder. In that respect, education combined with training and proactive leadership, enables cultural change within the CF as an organization.

595 Second, education and training enables members at all ranks to recognize the signs and symptoms of PTSD, in themselves or others, and so get help quickly. It equips leaders and supervisors with the tools and knowledge they need to act as quickly, effectively and compassionately as possible. In my view, the CF leadership has a responsibility to provide members with that knowledge. As one soldier succinctly put it:

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> I think something has to be implemented so that leaders can spot the earlier warning signals of somebody who may be having problems, all the way up the chain. People need to know where to go and who to turn to.

597 Or, according to the Medical Advisor for the International Red Cross, "It is critical that people understand what [PTSD] is, how to recognize it, how to deal with it before it happens. We are all vulnerable."

598 A CF MO interviewed by Ombudsman's investigators also highlighted the importance of education in seeking treatment as early as possible:

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> I think one of the first steps is having a more open attitude, having more education regarding not just PTSD issues but other psychosomatic-type illnesses: depression, anxiety, panic attacks, sleep disorders. More education about the signs and symptoms of these illnesses, stating go to your MO, your Padre, your social worker, your mental health nurse for help.

600 Education and training can be a catalyst for cultural change within the CF. As one soldier said, "Once you understand PTSD you lose the prejudices and preconceptions." In my view, there is currently an unacceptable level of ignorance about PTSD and related issues in many quarters of the CF. As a very senior battalion NCM said:

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> I don't understand [PTSD]. I am like a lot of other soldiers. I don't really understand it. We read about it. You get people to tell you about it but, again, it's something to do with the brain and who can really understand that. I can't.

602 The investigative team often heard that, while CF members could easily relate to physical injuries, it was a huge hurdle for them to accept mental injuries as equally legitimate. As one member said:

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> The chain is trying to respond as best they can. The difficulty is the lack of education at the Master Corporal and Sergeant levels. When a person is acting in an unusual manner they have difficulty in finding the correct response. They want to do something concrete to resolve the situation but their attempts often compound the member's problem. I don't feel that in most cases this is based on malice but on the fear that "there but for the grace of God go I." The problem is long term but they want to be able to resolve it as quickly as possible and get things back to 'normal.'

604 A CO of a large base noted that because of ignorance about PTSD, combined with the nature of mental illness, "the CF has not dealt with [PTSD] very well at all."

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> The lack of appreciation for what [PTSD] issues really are, perhaps, the lack of education as to what it really is ... I think that's why we dealt with it poorly. I don't think in broad terms we understand what the situation is ... Maybe it's through ignorance of what the problems are, but in some cases it is an inability to understand. The system does not lend itself well to someone with a problem that is not visible. If a member comes back and he or she is missing an arm or a leg, it's visible and you empathize with that. You say we'll try and do something about that. But when the problem isn't visible, the education isn't there and the understanding isn't there, it becomes something different. Totally different.

606 Ignorance about PTSD underpins the way members who have been diagnosed with the disorder are treated by their peers and leaders.

The more educated members are, the more likely PTSD will cease to be the stigma and mystery it is at present; and the more likely its treatment at an earlier stage, the far greater the chances of recovery for those afflicted with PTSD. One NCM advised compulsory education to combat ignorance:

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> … it's just the simplest ignorance … Senior NCMs and officers should know how to recognize [PTSD symptoms]. The best way is … massed knowledge enforced on members. They won't like it. They are going to yell and scream, but that's the way it is because we don't like change in the military …

608 Another senior NCM replied to a question by Ombudsman's investigators as follows:

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> Do we need awareness training? Yes … Leaders must understand this condition and prepare not only their soldiers, but also themselves … I believe there is a severe lack of understanding regarding the important issues surrounding training and education in both PTSD and CISD. We have spent countless hours dealing with gender equality, harassment and media negativity rather than focusing on the issues of looking after our most precious resource, the soldier. Prior to our '97 deployment the leadership received a two-hour presentation on CISD, which in fact was supposed to be a one- or two-day awareness program. This was unacceptable …

610 Cultural change through education is not a speedy process, as other organizations that have tackled mental health issues have discovered. Dr. David Hoath, a psychologist in charge of the Ontario Provincial Police (OPP) Workplace Support Unit, remarked:

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> Culture change is a long-term project. It takes 10 or 20 years. The keys are education and leadership. If the leadership takes it seriously, everyone has no choice but to follow whether they like it or not. There has to be zero tolerance and sanctions if necessary.

612 Similarly, according to a senior NCM at LFWA:

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> … the crux of the issue is that people in our position are going to deal with a lot more instances of people with PTSD. I think there needs to be an educational awareness. You are not going to dispel people's

> attitudes right off the bat. You are not going to change people's attitudes overnight.

614 Other comments along the same lines included the following:

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> I think a lot of it has to do with having an open attitude and education. A lot of people are aware of PTSD, but there is that stigma attached to it, especially in the infantry. They have that tough mentality, you should stick it out, keep going. A lot of stigma is related with those types of diagnoses, PTSD or depression. (CF caregiver)

616
> I think there are a lot of soldiers who do not understand what PTSD is, apart from the unfortunate ones who are suffering from it. The best thing we can do is educate them. (Company Commander PPCLI)

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> … people would behave better if they know better. (CF member)

618
> … the best thing we can do is to educate CF members. (Maj PPCLI)

619
> Maybe these guys aren't all fakers. I think the people who are in the front line need to be educated. (Maj LFA Area)

620 Moreover, education and training about PTSD and stress-induced illness must be a continuous process, according to a broad cross-section of individuals to whom the investigative team spoke. They stated that CF members should receive regular training on the issue.

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> There is not enough education. The CF should be teaching about PTSD yearly whether or not a soldier is deployed. Training about PTSD should be part of unit training, just like driver training or weapons training. (WO LFWA)

622
> All operationally deployable CF members should be thoroughly educated on the probability of the development of PTSD. This should be done by professionals, perhaps during basic CF training, phase or [qualification] training and as part of predeployment training. (Social Welfare Officer)

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> We must build upon prevention, particularly with regard to education, psychological fitness and spiritual

> fitness. Further to spiritual fitness we must enable people to create meaning out of suffering and tragedy. (CF Padre)

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> … everybody should be educated but it's way too late to start at the battalion level. (Sergeant LFWA)

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> I feel that CIS/PTSD education should be given at every level of the training system. For example, a new recruit receives a lecture on basic training then again on all new QL [Qualification Level] course qualifications, on JLC [Junior Leadership Course], on SLC [Senior Leadership Course]. Since studies have shown we retain only approximately 15 percent of what we hear, the repetition would add to the knowledge base each time. We provide first aid training for the body regularly, why not provide first aid for the mind? Of course, to access the students, one has to access the Training Plan, which I have discovered is difficult! I think it's carved in stone. (CF caregiver)

626 The CF has recognized the negative effects of insufficient knowledge about health issues in general, and mental health issues in particular, among CF members. According to the most recent *CDS Guidance to Commanding Officers*:

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> Numerous reviews of health complaints of Canadian Forces (CF) personnel have noted a general lack of knowledge by CF members at all rank levels concerning key health issues. Most knew little about stress related illnesses such as post traumatic stress disorder and functional somatic syndromes. Many were also unfamiliar with more widely publicized issues such as post deployment illnesses. This has led to very destructive attitudes, which on at least one occasion probably contributed to suicide by the member affected. Although a 'can do' attitude is required to maintain a cohesive fighting unit, it is also important to understand that illness, whether physical or mental, can make it impossible for a person to contribute to the success of a mission. It is equally important to understand that return of our ill and injured personnel to full health and functioning strengthens all aspects of our defence team.

628 Cpl McEachern's senior chain of command has acknowledged the importance of education and training about PTSD and, by implication, current deficiencies in that regard. One of the recommendations of the LFWA administrative investigation conducted into the incident involving Cpl McEachern reads as follows:

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> Improve PTSD Education. Education on PTSD should be included as part of formal leadership courses within the CF. The Commanding Officers Course should have a major presentation on PTSD and the SPHL.

630 I fully endorse this recommendation.

631 In her interview with Ombudsman's investigators, the psychiatrist at the OTSSC in Edmonton who treated Cpl McEachern described the need to educate CF members at all levels:

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> [PTSD has] come to the forefront again, which is great, but there's still a huge amount of education to be done ... and that's not just at, you know, the Private levels. It should be happening right at basic training level and all the way through. We have a huge job ahead of us to do that ... There's education to be done even at a very basic level, basic training. When people come in for basic training, they get education about firearms. They get education about, you know, the military culture. They get education about the rules and regulations that are expected of them. They also need to get education about the stresses that they may be exposed to in the military, and they need to have some training around how they can help themselves deal with those things. Okay, so you can start that kind of thing very early on in training and talk about things like depression and anxiety. You don't have to ... give them an open door and say, you know, everybody who comes in here is going to experience post traumatic stress disorder and ... if you go on a tour you're going to come back as damaged goods. No, that's ... not what the purpose of the education is. It is [that] everybody will experience stress in his job and these are some of the things that you can do to help to alleviate that and take care of yourself, right? So, we can start with that at the very basic level and then, it'd be wonderful ... at the unit level and at any kind of the junior and senior leadership courses ... I know they put in courses around mental health care, expand on that a little bit, it's a huge opportunity for training to talk about ... What is stress? What is mental health? What does that mean? How does that fit in with good leadership and morale? ... because I see those things as all being tied in together. And for instance on this base in the last

> year or two, the Area Social Worker and … went to the CO's meeting a few months ago, we went to … professional development for the officers and those were a couple of places that kind of invited [people] to come and just talk in general about those issues and about a little bit of PTSD specifically, just in a very, very brief form. We talked about stigma too, and that's great … If we can just expand that now by … about 100 … and be doing that, you know, at the grass roots level and all the way up … then I think we … potentially can make a huge difference. I just need the resources to do that.

633 Another senior caregiver also identified the need for ongoing education and training about mental health issues throughout a member's career:

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> I mean, what needs to happen is education. That starts from the CDS level, that goes down. I mean, we have to look at how … when people join the Forces, What do we tell them about mental … about resources? You know, we tell them that this is your buddy, we start at basic training to take care of one another as a buddy system. Well, the buddy system, it's not just like if you lose your wallet, you know … we have to start thinking in terms of … being able to support one another, and to … start letting them know what are the stressors in that environment. What are the resources available, and how we perceive it. It has to be part of the indoctrination … You know, this is what is needed, and you do it not only at the basic training level, because everybody sleeps through that most of the time. But you keep bringing it back at different courses, you know, every course that you go to, you develop that, not only for junior rank officers, especially officers, you know, at every training opportunity.

635 There were a few dissenting voices. One former United Nations Military Observer stated that additional training was not the solution; others suggested that members are already overburdened with training. However, the overwhelming opinion expressed to Ombudsman's investigators was that the current state of training on PTSD is seriously inadequate.

636 Perhaps the need for ongoing training and education was best summed up by a senior NCM from LFWA, who indicated that, in his view, PTSD is an extremely serious problem that is not currently being tackled. He does not have PTSD, but knows of many colleagues who are symptomatic or have been diagnosed with the disorder and is appalled by the way their leaders and peers have treated them. He identified education and training as part of the solution when he told my investigators:

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> I honestly think that there is hope for the CF to survive from this challenge and to serve the greatest country in the world. What are needed are the tools to better train and prepare soldiers from their initial enrolment and throughout their service careers. To not do this, is criminal. How many are to fall before we act?

638 In my view, it is readily apparent that, in spite of recent improvements, the CF has much work to do to achieve the levels of education about PTSD that are required. The consensus among those within the organization who are well-informed on PTSD and related issues, particularly among mental health caregivers, is that the CF is not doing a good job of educating its members about PTSD, even though there is a growing awareness of the problem. That view is shared by at least some within the education system. As a senior officer involved in the CF education system commented:

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> I can tell you that [CIS Training] is not one of the main courses taught here [at a CFB Borden school]. It might be a useful leadership skill to be embedded in our school in the future. I have just been posted to this school after approximately 10 years [at an operational infantry unit] and two operational tours ... and the only time I saw any training on this important area was as part of a work-up for an operational deployment or offered as a specialized course by 'PTSD expert instructors'. Ironically, I had my only formal training [Peer Counsellor course] in this area when I returned from [an operational deployment] in 1993.

640 A senior NCM with many tours under his belt summed up what appears to be an accurate assessment of the paucity of education about PTSD in the CF:

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> There has been a little bit [of education and training] but nowhere near enough, especially at the command level. The command level is either unwilling or uneducated about [PTSD].

642 Education and training is the key to the cultural change within the CF. However, education and training require resources and time.

While I see no reason why curricula in CF educational establishments cannot be modified to comprehensively and effectively deal with issues related to PTSD, the issue is not so clear-cut with respect to operational units. My investigators were told that imposing educational and training requirements about PTSD on operational units would backfire unless the workload could be lessened in other areas. According to one caregiver with considerable operational experience:

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> I don't see any initiative that requires supervisors' taking time away from their current tasks in order to participate in the initiative to have any hope of success without giving supervisors the additional resources they would need to continue doing their jobs. In other words, the troops are maxed out with what they have to do now, such that if they're made to do something then the leadership will have to tell them what to stop doing. Trying to add to their current burden will only cause resentment and bitterness, which will have an effect opposite to the desired one. And I'd rather keep it the way it is than see anything done to make it worse.

644 Given the fast pace of operations, the CF is going to have to make some hard choices. However, I believe that PTSD is such a significant issue, particularly for recruitment, retention and commitment to the welfare of all CF members, education and training about PTSD has to be made a priority. The CF has successfully introduced gender integration and harassment education for its members. I see no reason why an equally firm commitment cannot be made to education about PTSD.

Comparison to other organizations

645 The investigative team spoke to or had contact with several police agencies, including the OPP, the Canadian Police College (CPC) and the Metropolitan Police Service in London, England, to determine what stress-related training they provide to their members.

646 The OPP Employee Assistance Program has a mandate to assist OPP employees and their dependants in finding help for mental/emotional, family, substance abuse, health or other personal problems. The OPP Workplace Support Unit (WSU) has a specific mandate to assist members who have been involved in critical incidents such as police shootings. The WSU also teaches members about stress arising from police work in general. It is staffed by a full-time psychologist and an outreach worker.

647 The OPP began to introduce stress-related training in the mid-1980s. Training begins at recruit class and is an integral part of the curriculum. In the view of the WSU psychologist, training lends a sense of legitimacy to issues related to stress, CIS and PTSD. He feels that such training sends a message to each member that the organization takes these issues seriously.

648 In comparing how other jurisdictions deal with stress-related issues, probably the most useful perspective came from Reserve Force members of the CF who serve as civilian police officers. While acknowledging considerable differences between policing and military duties, they indicated that police agencies are far more proactive in dealing with stress-related issues than is the CF. As one of these members said, "Specifically, with training with the police force, they do an excellent job of preparing us for what we are going to take on the street and take home with us after we are done. As well, they invite our families to these lectures." When asked to compare how the CF deals with stress compared with how his police force handles it, the member stated:

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> ... there is more secrecy, more privacy in [the police force]. If I have a problem I know everything is going to be OK. I can talk to this person. I can bring my spouse in. We can work it out without fear of repercussion. The [police force] handles it well and I don't think the Army does yet. Maybe they are getting better, I don't know. I hope they are for the soldier's sake.

Effective delivery of PTSD-related education and training

650 All the education and training in the world will not make any difference unless it has credibility with its intended audience. Ombudsman's investigators examined the most effective methods of delivering education and training, including deployment-related briefings and debriefings to the target audience.

651 Currently, most formal education and training about PTSD is delivered by professional subject matter experts (SMEs), such as medical doctors, social workers, chaplains, PSOs or a combination of the above.

652 In many instances, using an SME is an effective way of training CF members. This was particularly true of recent tours in which mental health professionals were deployed for the entire tour and had direct knowledge of what members had been through. Similarly, there has been nothing but praise for outreach efforts by OTSSC staff; for example, this Office has received glowing reports about OTSSC outreach in Halifax and Edmonton. OTSSC staff members have been invited to speak at professional development days and at mandatory first-aid courses. At time of writing, OTSSC staff were scheduled to meet in Halifax in November to discuss ways of improving outreach initiatives even further. Elsewhere in this report, I have recommended that outreach initiatives by OTSSCs be expanded. In addition, many CF social workers, padres, PSOs and others in the system are doing as much education and training as resources and opportunity permit.

653 However, the consensus among members at all ranks to whom Ombudsman's investigators spoke was that training delivered *exclusively* by SMEs not directly associated with the target audience or with no direct experience of what the target audience goes through had little credibility. The reigning attitude was summed up by one member who pleaded, "Please don't send us the men with pony tails." Investigators heard frequent complaints from troops that many individuals tasked to deliver training, such as social workers or medical doctors, from outside a unit had little or no concept of what the audience had been through. One senior NCM with a wealth of tours under his belt put it the following way:

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> You have the doctors and you have so and so from Ottawa, civilians and all of that, and everybody in the audience is going, "here's a guy pulling down $125,000. He has come here to yap at me using 26-letter words and diagrams and flow charts," and everyone will just yawn.

655 Cpl McEachern's former Company Commander's view was fairly typical when asked how effective education and training was:

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> You have a very clinical, dry, slide-projection type of briefing. Yes, PTSD is covered. It depends on the individuals who are giving the briefings. I think there is more value in the discussion if you have people who have been there and experienced it.

657 Suggestions to improve the impact of training about PTSD were put forward.

658 There was a feeling that members who had been deployed could most effectively deliver training. Another senior NCM told investigators:

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> … we must develop programs designed to train our soldiers prior to an operation, which addresses the trauma … they may have occasion to be exposed to. The major problem is that we have utilized personnel with educational requirements, but lack the reality skills or experiences of what soldiers are exposed to in an operational environment. This is not rocket science.

660 Another soldier noted the importance of having trainers of the same rank as their intended audience. He commented:

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> If a soldier hears about [PTSD] from General So and So … it is going in here and it is coming out there. If Sergeant So and So talks to him, or Master Corporal So and So talks to him, or even Warrant Officer So and So talks to him, he can relate the exact same experiences because they have been there together. Whereas Captain So and So hasn't. Major So and So hasn't.

662 Education and training must reflect the audience it seeks to inform. Ombudsman's investigators found an overwhelming consensus among individuals of most ranks that the most effective way to create an understanding of PTSD would be to include educators/trainers who had been diagnosed with PTSD and had been through the system themselves. Several OTSSC staff acknowledged the benefits in having members or former members who had been diagnosed with PTSD involved in education and training as part of a multidisciplinary approach. Many members referred to LGen Dallaire as an example of how effective education by those who have been diagnosed could be; his 'coming out' was seen as a huge step in awareness of PTSD within the CF. In fact, even members who were most sceptical about PTSD conceded that some PTSD cases are genuine, referring to LGen Dallaire or the *Witness to Evil* video as examples.

663 The investigative team found other examples of the benefits of education delivered by those with direct experience of PTSD, speaking candidly in a relaxed and nonjudgemental forum with

their peers. One of the first senior NCMs diagnosed with PTSD in the CF told the team of a recent speaking engagement at a mess dinner for senior NCMs:

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> After I had spoken — we talked about Medak, but I had basically made the point about how I was diagnosed with PTSD, and explained that if it could happen to me — they were a Reserve unit — a veteran in the forces, it can especially happen to untrained soldiers. After that, there were eight or nine guys who came up to me [and said], "You know, I've been feeling kind of like that." I said, "You need to get help and you can't be afraid to do it." [They said] … "I'm going to lose my wife." I said, "That's the reason why you should go, because of that." "Yeah, but if I do that I'm kissing my career, like you are kissing your career." I said, "Yes, I understand I am kissing my career goodbye. But what's more important? Your health? Your family. Or continuing on trying to avoid."

665 As noted, the investigative team heard that education and training must be provided, in part, by a peer group, at equivalent levels (junior NCMs speaking to junior NCMs, senior NCMs speaking to senior NCMs, and so on). Anecdotal evidence indicates that senior NCMs would particularly benefit from exposure to soldiers of their own rank who have been diagnosed with PTSD and who have carried on productively.

666 There is a large pool of current and former CF members with PTSD who are willing to participate in this process. Many of the members Ombudsman's investigators interviewed spoke eloquently about their own experiences. As noted elsewhere in this report, the vast majority of these individuals are or were above-average soldiers who would likely have credibility with all but the most recalcitrant of their peers. I believe they would make extremely effective educators at all levels in the CF. As one of them said:

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> You have to have been there. Like me. I would show up in CF's and I would have all my bells and whistles on. I have nine medals. So I stand up there and I say, "Okay guys, the bullshit is over. I am reality. I have been through this. Anyone out there who thinks that I am bullshitting, put up your hand and we will get this out in the open. Who here thinks I am scamming the system? … Come back to my house and at two o'clock tomorrow morning when I am outside throwing up all over the fence, then you can tell me that I am bullshitting. You can tell me I am bullshitting when out of 365 people [on a tour], 11 are dead."

668 As one serving member with PTSD, who had given the issue of effective training considerable thought prior to the incident involving Cpl McEachern, told investigators:

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> One of the things I am mulling over in my mind right now if there is any way that I can get to the rank and file soldiers in the brigade, and not brief them, no, rather sit them down in a lecture hall and lecture to them, teach them, this is PTSD. This is what it looks like. To actually get them in a more casual atmosphere with ... I have four volunteers who are willing to come forward with me and go and talk to the troops at separate rank levels. Not gather all the NCMs together. Gather the Privates together, talk to them as a group. Talk to the Corporals as a group, the Master Corporals, the Sergeants and the Warrants together, then your Master Warrants and your Chief Warrant Officers. But sit them down across the table from real PTSD sufferers. Because, let's face it, we are the subject matter experts on PTSD. We are the ones who are living it, not the doctors. We're the ones trying to deal with it every day.

670 Another senior NCM who had been diagnosed with PTSD and was in the process of being released agreed that members could best be educated by people who "had been there":

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> I will tell you what you need and it will work. You need a team of people like me. You need people who have experienced PTSD, to go in and speak to a battalion without any repercussions whatsoever.

672 That is not to say that responsibility for education and training should rest exclusively with those who have been diagnosed with PTSD. Those who deliver the education to CF members should collectively possess a blend of experience, technical knowledge and teaching skills. I envisage a multidisciplinary team, comprising CF members with PTSD working with mental health caregivers, social workers, padres, PSOs and other professionals to deliver training tailored to the audience. The teams would be co-ordinated through the office of the PTSD co-ordinator (see Part Eight).

673 The concept of teaming up professionals and those with intimate knowledge of PTSD has recently been field-tested during OP Palladium Roto 7, with apparent success. The Post Operational Report (POR)[12] reads as follows:

674 OP PALLADIUM ROTO 7 - 2 PPCLI BG – Oct 00 – Mar 01

675 UNIT Comments:

676 a. For 1RCHA, LdSH(RC) and 1CER, this was conducted by mental health professionals. For 2 PPCLI, the Wing Social Work Officer conducted the training assisted by an Inf[antry] MWO who had extensive experience helping personnel who had suffered from CIS and PTSD.

677 b. The combination of a mental health professional, equipped with academic and theoretical knowledge, assisted by a respected and experienced F Echelon soldier was outstanding. Generally, the greatest problem experienced by the mental health professional is that s/he does not share similar experiences or outlook with the F Echelon soldiery and so has extremely limited credibility. In this case, his credibility was greatly enhanced by the practical examples and personal credibility provided by the MWO. This method is strongly suggested for use when teaching this subject wherever possible. In addition the unit conducted Peer Defuser Courses such that there are two personnel trained per section. The most difficult aspect of this course remains candidate selection, with the aim to get sufficient personnel at the right ranks (generally peers work best to defuse other peers), with the credibility and personal characteristics to assure that they will be used properly.

678 The PORs were not as complimentary in cases in which professionals with no field experience were used exclusively to deliver training to deployed members. One reads as follows:

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[12] There has been a requirement since 1996 for units that have been deployed to submit information to ALLC in the form of a Post Operational Report (POR) at the conclusion of the tour of duty. The POR consists of a series of questions. ALLC processes this information as required by senior leadership.

679 This training was effective and the quality of instruction was good. It however lacked in personal experience.

680 Having members and former members diagnosed with PTSD deliver education and training about PTSD has a further benefit. Many caregivers indicated that talking about what happened is an important part of the healing process; many patients feel they could make a meaningful contribution to the well-being of comrades and former comrades. Obviously, any members or former members who offer to speak about their experiences would require approval from their caregivers to ensure they were fit to do so.

Rx 2000

681 In 1999, the CDS, Gen Maurice Baril, directed the Chief Review Services (CRS) to conduct a review of the CF Medical Services (CFMS) to identify how to improve in-garrison health care. The Rx 2000 project was created to implement the recommendations of the review, as well as others that arose from the Croatia BOI, the McLellan report on the Care of Injured Personnel and Their Families and the Lowell Thomas report. The DGHS, BGen Lise Mathieu, is responsible for managing and implementing this project under the auspices of ADM (HR-Mil).

682 The Mental Health Care Initial Working Group met in mid-February 2001 and developed concepts and recommendations for improving mental health care in the CF. During that workshop, 65 health care providers from across Canada and Europe examined current issues facing mental health service from a multidisciplinary perspective. At the end of the three-day session, the group agreed "to develop a Mental Health care network that maximizes psychological fitness of CF members throughout their service career while aiding members who develop psychological injuries and illness in a timely fashion and with an expectation of resumption of duty." Outreach activities and education were identified as important factors in this initiative. In a presentation to senior management in June 2001, the project manager identified the next steps:

683 - collate all data;

684 - design a preliminary mental health services model;

685 • incorporate mental health into CF health services delivery and clinic design — resources and infrastructure;

686 • develop mental health education packages; and

687 • initiate lay educational packages, with a focus on leadership issues.

688 Ombudsman's investigators spoke with a senior officer responsible for implementing the mental health program. She advised that the DGHS recognized that education of members about mental health issues was a pressing concern, and that the CF was committed to tackling the problem. CFMS intends to introduce a comprehensive plan to educate all CF members about mental health issues, including PTSD. CFMS staff have met with representatives of CFRETS and VAC, and intend to research the most effective methods of delivering education and training on this topic. Unfortunately, given a lack of available resources and other reasons, this program will not likely begin until at least February 2002.

CF communications initiatives

689 Objective, accurate and informative communications strategies are a crucial component of the education and training process for members and their families. The investigative team reviewed the communications initiatives that are being made to enhance awareness about PTSD on a CF-wide level. They are part of a series of measures being taken to deal with deployment-related mental health injuries and illnesses, and originate from various sources. According to the Director General Public Affairs, which has provided us with an overview of what is planned in this field, the CF is committed to the following initiatives:

690 • CF letter on deployment health. This letter will be introduced by the CDS.

691 • *Post Traumatic Stress Disorder (PTSD) and War-related Stress*. This publication, based on an Australian Defence Force (ADF) publication, is currently being distributed to CF health care providers.

692 • Member handbook. A handbook on deployment-related mental health injuries and illnesses is being developed by the CF Director of Mental Health.

693 • Personnel newsletter. A three-part series on deployment-related mental health injuries and illnesses was published in the fall of 2001.

694 • DND/VAC interdepartmental working group. A joint working group has been established to develop a resource kit for distribution to health care providers and CF members. The group met during the summer of 2001.

695 PSTC has also compiled two documents about deployment-related stress. The first, entitled *Preparing for Deployment Stress*, does not refer to PTSD, while the second, entitled *Preparing for Critical Incident Stress*, does. Both contain useful basic information and are available on the PSTC Web site.

Feedback on existing training and procedures for deployment units

696 PORs collect valuable feedback after tours of duty. Two areas on the POR deal with issues that have a bearing on this investigation. They are:

697 Question Series 21 — Individual/Critical Incident Stress Training

698 a. Who conducted unit stress training?

699 b. Was it effective (quality of instruction)? Could it be done better?

700 Question Series 94 — Post Operational Stress

701 a. Was there a co-ordinated Post Operational Stress program?

702 b. Who co-ordinated this program?

703 c. How was this followed up with personnel who were attached to the unit?

704 d. Was support required from outside agencies?

705 Sample feedback from the PORs in both areas have been used throughout this report. The overall feeling is that the training is effective and worth while. In general, feedback indicates the following improvements are needed:

- **706** training be given in both official languages;
- **707** a combination of mental health professionals and members who have experienced PTSD be used, as this is most effective (as already discussed);
- **708** sufficient time be allowed in the training schedule to deal with stress-related issues; and
- **709** Reserves and augmentees be given special attention in the post-deployment phase.

710 A most disheartening piece of information that came from ALLC was that Question Series 21 will be dropped from future PORs. ALLC advised that:

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> Due to a review of the POR content (questions) conducted by our section last November, Question Series 21 was dropped from what we call Version 2001 (the current version). OP PALLADIUM ROTO 8 is the first operation to use Version 2001. The fact that Question Series 21 is no longer included in the POR does not prevent a unit from commenting on the subject, however they now are not prompted to do so. The usual result in such a case is that submission of information on the subject drops off dramatically. The primary reason for the deletion of this topic was that there was no indication that anyone within the Army was or is today, on a routine basis, demanding or using the information gathered in Question Series 21 to conduct research or develop policy.

712 Given the critical need for data on PTSD, the decision to drop Question Series 21 from the POR should be revisited. The quality of the CF data on PTSD cannot improve without input based on deployment-related experience. In turn, the quality of data has a direct impact on the CF's approach to PTSD.

713 Another piece of disheartening news was from caregivers who had been deployed in theatre for extended periods, and in particular to conduct reintegration briefings. Their feedback indicated that multidisciplinary teams on tours of duty was a success, but it is unclear if this practice will be continued.

Summary and recommendations

714 Based on feedback received from all parties, and subject to some refinements as to who delivers training as discussed below, I believe that outreach programs by OTSSCs should be given sufficient resources to provide training to as many units as possible, with the ultimate goal of having OTSSCs participate in the delivery of training to all CF units.

715 In my view, peer support training is an excellent tool, not only for the skills it teaches, but also for the wide exposure about stress-related issues it offers. It allows CF members in the field to recognize symptoms and encourages them to seek treatment at the earliest juncture, which is the key to successful recovery from PTSD.

716 I therefore recommend that:

5. **The Canadian Forces initiate a program whereby all units receive outreach training about PTSD via the OTSSCs.**
6. **OTSSCs be funded to a level that ensures they have sufficient resources to deliver quality outreach training to units on request.**

717 Ombudsman's investigators were told that courses are currently overflowing, leaving little room to add issues related to PTSD. While that may be true, it does not absolve the CF of its responsibility to provide the education about PTSD that is so desperately needed at all levels. According to a former senior officer with intimate knowledge of the training system:

718
> You start at junior education level by someone who is credible ... You need days added on because courses are already jam-packed. Officers should have a higher level course including instruction on how to recognize and to treat PTSD, but everyone at every level should be aware.

719 Simply put, PTSD is such an important issue, room to educate CF members must be found. The human and financial costs of not

educating members dictate that education about PTSD must become a priority.

720 I therefore recommend that:

7. **Specific and detailed education and training objectives dealing with PTSD be included in the curricula of all Canadian Forces educational and training establishments, and that the performance measurement criteria for these organizations reflect these objectives.**

721 I wish to emphasize again that there are success stories. It is not uncommon for members who have been diagnosed to do their jobs, and do them very well. But in virtually every success story that my investigators encountered, the key factor was support from the member's unit, even in instances where members chose only to advise the chain of command and not their peers. However, the support most often related to the awareness of PTSD by both peers and leaders within the unit.

722 I therefore recommend that:

8. **Canadian Forces units be mandated to provide ongoing continuation training about PTSD to all members at regular intervals, in addition to any deployment-related training.**

723 To sum up, education is one of the areas in which the CF appears to be most deficient in its approach to PTSD, particularly with respect to the provision of even basic knowledge at the recruit and leadership levels. Conversely, deployment-related education and training is becoming more comprehensive and sophisticated, particularly at unit level. The current overall quantity and quality of training and education is insufficient to meet the needs of the CF.

724 In Part Eight of this report, I recommend that the CF appoint a PTSD co-ordinator responsible for advising and co-ordinating action on PTSD issues across the CF. I envisage that the PTSD co-ordinator would play a central role in education and training initiatives about PTSD in the CF.

725 I therefore recommend that:

9. The Canadian Forces make PTSD a mandatory part of education and training at all ranks and that educating Canadian Forces members about PTSD be made a priority.

10. The office of the PTSD co-ordinator play a central role in the education and training process by acting as a resource and advisor for bases, formations and commands.

726 In my view, there is considerable evidence that, to have maximum effect, education and training about PTSD to CF members should be delivered by multidisciplinary teams, including members or former members who have personal experience of PTSD.

727 I therefore recommend that:

11. The Canadian Forces include members or former members who have experience of PTSD in all education and training initiatives relating to PTSD.

12. Multidisciplinary teams that include all of the professional specialties with an interest in PTSD diagnosis and treatment, including experienced soldiers, be used to deliver outreach training. To enhance training effectiveness and ensure standardization, such training should fall under the control of the office of the PTSD co-ordinator.

728 I appreciate that the Rx 2000 project has to tackle many issues and it is necessary to set priorities. However, in my view, the need to provide effective training and education to all CF members about PTSD is of such immediate importance that I believe that the ADM (HR-Mil) should allot additional resources as required to begin the mental health program as quickly as possible.

729 I therefore recommend that:

13. The Canadian Forces allot additional resources to accelerate the implementation of the proposed mental health education initiatives developed by the Rx 2000 Mental Health Team.

Part Five:
Deployment-related training and procedures

730 There has been a huge improvement in the quantity and quality of training about PTSD prior to, during and post-deployment over recent years, largely owing to increased awareness by individual leaders who have been proactive in informing deployed or deploying members. Another reason for the improvement is the existence of outreach programs conducted in the field by qualified professionals, in particular OTSSC personnel. The CF has also deployed mental health professionals for the full duration of operational tours and is considering deploying social workers on the same basis. Part of their function will be to provide training on issues related to PTSD in the field.

731 However, a tremendous amount of work remains to be done in this area. As recently as 1997, a CF soldier told researchers that he had been on six deployments and yet had only received one deployment debriefing, which consisted of a single question: "So everything alright then?" In another case, a reunion briefing was held in a hall with hundreds of other soldiers — six or seven weeks after the contingent had returned home.

732 While the various Land Force Areas have or are developing policies to deal with deployment-related training, there appears to be no clear, overall CF-wide policy. This may have its advantages in that the training can be customized to meet the needs of individual units. However, the specifics of how and when exactly such training is delivered appears to be done largely on an *ad hoc* basis by individual units.

Land Force policies

733 The last CFAO (CFAO 34-55 — Management of CIS in the Canadian Forces) on the topic of deployment training about PTSD was issued in 1994. Land Force areas have been given the discretion to adopt approaches best suited to their own requirements.

734 Ombudsman's investigators asked the Area Social Work Officer at the OTSSC in Edmonton to provide a synopsis of current deployment-related training about stress-related illness at LFWA. She described training prior to, during and post-deployment available to CF members and their families, as follows:

735 Prior to deployment every soldier is given a Pre-deployment Briefing with handouts, which covers the following: preparing family for soldier's absence, stress management techniques, deployment stress identification (effects and management thereof), and presentation on CIS (traumatic events) and what resources available in Theatre for Defusing and Debriefing. Presentations for families available through Family Resource Centres.

736 Prior to deployment approximately 10 percent of the Contingent will receive Peer Support Training (four-day course). For example if 1,100 soldiers are to deploy, 110 or more will be given training to provide psychological first aid to their peers plus assist with Defusings and Debriefings. Soldiers will receive training in recognizing signs and symptoms personnel exposed to a Critical Incident/traumatic event may have and intervene appropriately. Peer Support Personnel also receive training in Suicide Prevention/Intervention. They also will know when to a make an appropriate referral and to whom (Medical Officer, Padre, Med A [Medical Assistant], other resources).

737 In Theatre, the Military Psychologist co-ordinates all Debriefing activities and monitors the stress level of the Contingent and develops appropriate responses as required. The Military Psychologist, Padres, Medical Officers, Mental Health Nurses and Peer Support Personnel provide all group Defusings, Debriefings and follow-up.

738 Approximately one month prior to return of the Contingent, Reintegration Briefings are provided to the soldiers. Recently, the Military Psychologist and Padres have provided this service. The Briefing is to allow for examination of the Tour (personal, experiential, good-bad, etc.), provide for the initial expression of emotion and examine issues surrounding reintegration with family (spouse, children), community and Garrison, as well as, in the case of Reservists, returning to their home unit. The Reintegration Briefing is also available to spouses and parents of soldiers through the Military Family Resource Centres.

739 The Post Deployment Briefings begin approximately six months after Tour. This is the last opportunity to remind soldiers that if they are still having difficulties

> with reintegration or are troubled by in Theatre experiences, that this is the time to do something about it. Experience of other soldiers indicates that unresolved issues at this stage are not likely to dissipate. Various resources are listed with phone numbers including presenters. In addition, personnel can see the presenter after presentation. Soldiers and spouses have the choice of attending a group session, meet individually with presenter or meet with presenter as a couple.

740 This approach is an LFWA practice, and is not standardized across the CF. Ombudsman's investigators examined the following directives by Land Forces Central Area (LFCA) and Land Forces Atlantic Area (LFAA):

741 • LFCA Deployment Stress Management Program (LFCAD 9-1-005); and

742 • LFAA Deployment Stress Management Program (LFAAD 5. 3. 6.).

743 Both directives have similar procedures to those found in the LFWA Directive. However, there are some differences; for example, the LFCA Directive provides that all LFCA units appoint an Office of Primary Interest (OPI) to co-ordinate the deployment stress management program. In addition, an assisting officer is appointed for any soldier who has been physically or psychologically injured. The task of the assisting officer is to ensure that the injured soldier "receives optimal administrative and medical support during any applicable recovery, rehabilitation, or release period."

744 The LFCA Directive recognizes that stress-related symptoms may not appear for a considerable period of time post-deployment. It notes this is of particular concern for Reserve members and augmentees who may have returned to their home units and may "fall between the cracks before difficulties have become apparent." For that reason, the directive provides that special efforts are to be made with Reserves and augmentees, including regular contact with the 'home' unit during and after deployment. The directive mandates that Regular and Reserve Force augmentees and UN Military Observers will receive a reintegration screening interview on three separate post-deployment occasions: within four to six weeks of repatriation, approximately six months post-repatriation and approximately 12 months post-repatriation. The purpose of the screening is to identify any health issues at the earliest point and get help for the member as soon as possible.

745 The LFAA Directive has a similar approach to the post-deployment process. It provides that all deployed members will have a 'reunion briefing' three to four weeks prior to return to Canada. The briefing "shall include aspects of stress management as well as strategies to cope with individual and family adjustment." Further, the directive provides for continued screening for Reservists and augmentees. Home units must be made aware of any incident on deployment involving an augmentee that "could possibly be perceived as troublesome." All returning Reservists and augmentees remain with their deployment units to complete Arrivals Assistance Group procedures "as a condition of employment." Additionally, all members complete formal reintegration screening within six to eight weeks following UN leave. The directive provides that "every effort will be made to include the member's partner in the screening process."

Predeployment screening

746 Predeployment screening is designed to identify any member who should not be sent on a particular deployment for a variety of reasons, including medical, personal or psychological. Soldiers suffering from stress-related problems have actually been known to volunteer for a deployment, hoping that it will help them "feel better." For many members diagnosed with PTSD, the last time they can remember feeling 'normal' was when they were deployed, a feeling expressed by many of the soldiers interviewed by Ombudsman's investigators. Accordingly, it is important that those who are beginning to show symptoms of PTSD not be deployed. This requires thorough predeployment screening, including interviews with family members, to ensure symptoms are not made worse by multiple deployments.

747 Predeployment screening is often inconsistent. In some cases, it is clearly considered a technicality to be got out of the way as quickly as possible. Persistent shortages of personnel at the unit level exacerbate the problem, increasing the pressure to complete predeployment screening quickly (and successfully). For Reserve and Regular Force augmentees, screening done at the home unit can vary from thorough to non-existent. Spouses are frequently not consulted, often as a result of the members' desire to exclude their partners from the process. As a result, much of the potential of predeployment screening to identify problems is lost.

748 The problem is not easy to solve. Issues of medical confidentiality and family privilege complicate predeployment screening.

However, screening is an important aspect of deployment that must be addressed: both the individual member and the CF as a whole lose out when it is necessary to return a member to Canada in the middle of a deployment.

Critical incident stress debriefings

749 The CF currently practises CISDs after a critical incident in theatre. Many civilian police agencies use the same practice when their members are involved in such incidents as police shootings or other life-threatening situations. Although a debate is apparently emerging among caregivers as to the effectiveness of these debriefings, on the face of it, they appear to be far more useful than the previous practice, which was little, if any, formal debriefing after an incident in theatre. Cpl McEachern stated that he had not received any formal debriefing after incidents he had witnessed, and suggested mandatory debriefings for soldiers after critical incidents would be valuable:

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> PTSD needs to be approached like a police department does. The second the guy touches his gun, or has a critical incident, the guy is forced to go see the army psychologist … [everyone] should have to go and be debriefed after a critical incident by somebody that's somewhat qualified or has compassion of the situation. That way you're not forcing the individual to come forward … and speak and even the guys that are tough and not coming forward have problems with what they've seen, they're just not going to admit it … so it needs to be a mandatory process where … everybody has to go, no matter what rank you are, no matter how you feel about the situation, everybody's got to come forward and talk about it and the situation needs to be documented and just like a police force even a minor incident such as pulling your gun or having to use an escalation force, that's an adrenaline rush and it needs to be talked about that, you know, well it's okay that you cried or it's okay that you felt totally pumped up or it's okay that … you know, it's a normal reaction to an abnormal situation …

751 It would appear to be important that members are debriefed about PTSD symptoms, both generally and individually, at times when they might need assistance in coping with symptoms of stress. Mandatory debriefing sessions to all members deployed in high-stress operations are also important to remove any stigma attached to attending sessions on an individual basis. At the same time, an individual session or sessions with a caregiver or peer who has been properly trained can go a long way to nipping any potential problems in the bud.

In-theatre reintegration briefings

752 Very recent rotations appear to be dealing with stress related to redeployment and reintegration far more effectively and systematically. In November 1999, a team of four military social welfare officers (SWOs) from Canada were deployed to Kosovo to facilitate post-tour transition and reintegration for the 1,145 soldiers deployed on Operation Kinetic Roto 0. The SWOs met with groups of 15 to 20 soldiers. One goal of the meetings was to facilitate discussion on stress-related issues and provide information on resources. In addition, the social work team provided direct counselling for 67 soldiers while in theatre and conducted CISDs. The SWOs also made direct contact with mental health resources in Canada for soldiers who required such assistance.

753 The exercise appears to have been successful. In a survey of CF members in the contingent, 61 percent indicated that the reintegration session was useful. More significantly, 67 percent of members surveyed indicated that it would be useful to have a social worker deployed for the duration of the tour.

754 Consideration is apparently being given to deploying social workers for entire tours, as recommended by the SWO team deployed to Kosovo in their post-deployment report:

> **755** … it is therefore strongly recommended that a SWO be deployed through a pilot project with Op Palladium Roto 6. CO 1CMBG supports the pilot project, as do the majority of KFOR Commanding Officers briefed after [the] workshops.
>
> **756** The Social Worker's role could include, but not be limited to, the following:
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> **757** a. assist COs with repatriations, either to prevent [premature] repatriation or to provide written psycho-social assessment on courses of action

available. It is respectfully suggested that written documentation may assist COs in personnel management;

758 b. to establish ongoing training, including but again not necessarily limited to CIS Peer training, anger and stress management, conflict resolution, mediation, suicide awareness;

759 c. to provide clinical support to Medical Officers, Nursing Officers, Medical Assistants, and Chaplains.

760 In May 2001, LFWA issued a draft policy directive entitled Redeployment/Post Operational Deployment Personnel Requirements (LFWAD 3-1-029). The directive deals with issues related to stress from redeployment (that is, being sent home) and the need for decompression and reintegration.

761 The introduction to the directive acknowledges the importance of dealing with post-deployment issues to operational efficiency and the welfare of members and their families as follows:

> 762 The current operational tempo combined with relatively limited personnel resources requires that CF soldiers deploy on operational missions on a frequent basis. During these operations, members may be subjected to hazardous and stressful conditions, and can incur physical or psychological injuries, some of which may not be immediately apparent.
>
> 763 Multiple unaccompanied tours in a short period of time and prolonged absences from home following operational deployments tend to negate the recuperative benefits of post-deployment leave periods. This has a detrimental effect on CF members, their families and the operational capability of the CF in general. To ensure the well being of our personnel and to maintain a sustainable high level of operational capability, members returning from operations must be afforded time to decompress and reintegrate.
>
> 764 Leaders at all levels must place a high priority on ensuring that all possible steps have been taken to facilitate the decompression and reintegration of subordinates following an operational deployment. This includes creating an environment where members feel confident to deal with deployment-related issues,

> such as Post Traumatic Stress Disorder (PTSD), and receive professional treatment as required.

765 The directive divides redeployment briefings into three stages, as follows:

Pre-redeployment stage

766 Before returning home, all members have an in-theatre post-deployment stress debriefing, delivered by trained unit members, padres, PSOs or medical personnel. There is also a provision for the debriefing to be delivered in theatre by professionals from Canada.

767 Furthermore, unit COs must ensure that each deployed member receives a letter on the subject of post-deployment stress before leaving theatre.

768 The draft policy directive also deals with Reserves and augmentee members. The policy provides that, 30 days prior to repatriation:

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> Commanding Officers of deployed units shall notify the parent-unit Commanding Officer of Reserve members and augmentees and the respective formation Commander by message that the potential for a stress reaction exists within their members and must be guarded against. Commanders of any sub units attached to the operation shall also be similarly informed.

770 In addition, the CO of the deployed unit must inform the civilian physicians of Reserve Force members "of the need for post-deployment medical examinations" by sending a letter to the physician approximately 30 days prior to repatriation.

771 Members also receive a reintegration briefing within 30 days prior to departure from theatre, designed to make the member "aware of potential problems that might be encountered on returning to Canada and how to cope with problems if they do arise." In addition, members are required to complete a medical questionnaire, which includes a psychological component.

772 The policy also directs that reintegration briefings be provided to families in Canada prior to repatriation. These briefings are to be co-ordinated by the local SWO and the MFRC. There is a provision for briefings in specific locations for the families of Reserve members, if the number of Reserve augmentees in a particular location warrants them.

Redeployment stage

773 The policy provides that any person who has missed the pre-redeployment stress briefings in theatre will be provided with a briefing on arrival in Canada. In addition, all deployed members will complete a medical screening on arrival, which includes a review of all medical documents.

Post-deployment stage

774 In addition to the preliminary medical screening of all deployed members on arrival, all Regular Force LFWA members "will be required to report for a post-deployment medical screening within 60 days of their return from deployment." The policy recognizes that longer-term measures are necessary to follow up on medical issues, including psychological illnesses. Briefings designed to provide information to members and their families on assistance available to them will also be conducted by the Area Social Worker approximately six months post-deployment.

Receptions and debriefing post-deployment

775 Cpl McEachern stated that there was no debriefing whatsoever on his return from Uganda in 1996, a fact confirmed by his OC, who told Ombudsman's investigators that there was little or nothing in terms of post-operational debriefings either prior to departure from Uganda or on return to Canada, because the deployment had been, in his view, so uneventful.

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> We do our post exercise interviews, talk to the guys. I had concerns with a couple of the guys who had obviously lied about their personal situations. That was my focus, my main effort administratively, to sort them out before too much time passed.

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> Basically, the guys, because it was Christmas time, it was basically if you have any concerns, come speak to me now. We will get a social worker to speak to you. For those of you who don't have any concerns ... and everyone wants to get home for Christmas ...

778 There has been considerable progress in debriefing and redeployment for LFWA units since then.

779 The manner in which CF members are greeted on their initial return to Canada after a peacekeeping deployment is extremely important. Not only does the immediate reception symbolize the appreciation of the military, and indeed the country, for peacekeepers' sacrifices, but the debriefing opportunity and medical examination is also the ideal time to detect early symptoms of PTSD.

780 Although efforts to greet returning peacekeepers are made in most cases, Ombudsman's investigators found many examples (some recent) of slipshod receptions; this important step often fell through the cracks for augmentees from both the Regular Force and the Reserve. In one instance, on returning to Edmonton from a very recent rotation, augmentees were directed toward waiting taxicabs to local hotels while core battle group (BG) members were bused to the main garrison for a welcome-home reception. Many augmentees mentioned that, when they arrived back at their home units, few around them were aware that they had been deployed. Indeed, in one situation, the augmentees were welcomed back with full in-baskets and invitations to get back to the work that others had been covering for them. These examples are of particular concern given the widespread use of augmentees in BGs. A senior officer advised Ombudsman's investigators that in one recent rotation, "the BG [numbered] roughly 1,100 soldiers when you include mid-tour replacements, [and the] soldiers came from over 120 different units both Regular and Reserve across the country."

781 The thoroughness of the medical examination conducted on return from deployment is extremely important, both for detecting problems that may have arisen during the deployment and for establishing bench marks for VAC applications. Not surprisingly, the vast majority of returning soldiers report that they have no problems: for many soldiers, acknowledging a medical problem would entail a delay in seeing their families. Unfortunately, that declaration can be later held against them if they subsequently report a serious problem. Anecdotally, Ombudsman's investigators were told that on one occasion the VAC appeal board used this declaration to deny an applicant pension coverage.

Decompression

782 The LFWA directive defines decompression as "the process by which personnel transit from a busy, stressful pace of operations to the less stressful and slower tempo of a garrison environment." Ombudsman's investigators heard several constructive ideas about the best way to achieve decompression. One interesting idea to assist with decompression was advanced by the ACOS HS Del Capt (N) Margaret Kavanagh:

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> I made this pitch one time ... I think people need to come home from Bosnia on a ship and they have six days to come home and unwind. They can drink all the beer they want. You can get all the medicals done. You have a captive audience. You can get all the immunizations. You can give them all the defusions. They can sit and go over some of their issues with their buddies. Then when they get home they will have defused a bit and they can go home ... I am deadly serious but nobody takes me seriously.

784 One former senior officer interviewed by investigators suggested that members be given time to decompress together outside Canada prior to being repatriated; a unit deployed in the former Yugoslavia would spend a week in another country, immediately after the conclusion of the tour, to debrief and decompress prior to being repatriated.

785 The need for a decompression stage was studied by two military psychologists in a paper sponsored by the CF in 1997.[13] They noted that some members indicated a "need for a gradual transition out of the operational environment." Decompression could involve a "staging period" of a few days or longer, in which members could be prepared for the stresses of homecoming. The authors suggested that, if cost considerations precluded a "staging period" for all deployed members, those judged most vulnerable could be targeted. They recommended that "a decompression stage be interposed between the theatre of operation and home for members identified with, or at risk of developing, serious stress reactions or readjustment difficulties."

786 I am not convinced that keeping members away from their families at the end of a long tour is a productive or practical approach to addressing reintegration. Indeed, introducing an extension to the tour may increase stress levels for both member and their families.

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[13] Postdeployment Support: Guidelines for Program Development. Maj P. J. Murphy and Capt G. Gingras, December 1997.

Furthermore, the logistical and financial implications in pursuing such a course are considerable. However, given the critical importance of the phase immediately following deployment, all options should be fully explored to ensure the needs and well-being of CF members are being served.

Post-operational leave

787 The LFWA directive acknowledges the importance of reintegration, in which post-operational leave plays an important part. Traditionally, deployed personnel have been granted immediate leave to reunite with their families. The directive continues in that vein, by providing an "ample" period of leave "normally no less than twenty working days," for members immediately on repatriation, prior to return to normal duties.

788 There is some criticism of this approach. Many individuals interviewed by Ombudsman's investigators preferred a more gradual reintegration process after a stressful tour. For instance, members could work for half-days for a limited period of time on returning home, prior to taking an uninterrupted leave. This solution may give members an opportunity to decompress with their peers as well as reunite with their families. At the same time, it may reduce pressure on both repatriated members and families by giving each 'breathing room' to gradually reintegrate with one another.

789 A senior representative of MFRC indicated that families feel considerable pressure when CF members are parachuted full-time back into family life immediately on disembarkation. As she told investigators:

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> ... the concern is ... the guys are home and what happens once they get on the ground? They give them a month off and they're home twenty-four hours a day for a month. We encouraged them not to do that. It's not a real practical means of bringing the member back to the family. It's from one extreme to the other. They need to come back and touch base with the guys they've been living with for seven months, and nag a bit about the furniture being moved. They need to have a period of time like that, even if it's only half a day a week for a week. They need to have that, and the spouses do too. It's just too intensive now.

791 One WO with a tremendous amount of operational experience put it more succinctly: "Please don't throw troops at their families."

Deployment procedures in practice

792 Ombudsman's investigators looked at how deployment policies translate in practice. To that end, they met with several parties at 2 PPCLI in Winnipeg who had recently completed a tour in the former Yugoslavia. Overall, the unit had clearly taken a proactive approach to stress-related issues, and the chain of command was aware of the issues and responsive to innovative ways of dealing with them.

793 The unit appointed a senior officer as the unit administrative stress co-ordinator, with the responsibility to co-ordinate responses to incidents. Its comprehensive predeployment briefing process included briefings about stress for families as well as for soldiers. The chaplain, or one of eight social workers, interviewed every member of the unit prior to deployment and assessed whether he or she was emotionally fit to be deployed. They also re-interviewed augmentees, who had already been put through a screening process with their own units. The unit freed up four days of valuable predeployment training time to train peer counsellors, with the goal of one peer counsellor per nine or ten soldiers. It practised going through a critical incident and how to deal with members involved in the incident. It tested the flow of information to and from the chain of command, and identified and corrected any problems that arose. The unit also gave each soldier a pamphlet outlining the signs and symptoms of deployment-related stress, including PTSD; the MFRC was encouraged to circulate information about stress to families of deployed members.

794 The unit deployed to Bosnia with a mental health nurse. With the support of the chain of command, he, the chaplain, the MO and the caregivers formed a team that took a proactive role in dealing with any stress-related issues that arose. They tested their ability to react to incidents in training exercises on at least three different occasions during deployment; they provided ongoing education and training to peer counsellors; they visited each camp regularly and encouraged members to talk about how they were feeling. The team and the adjutant met regularly, often daily, to assess how the unit was doing from the perspective of stress.

795 While deployed, the unit had to deal with the deaths of two members, both from natural causes. By all accounts, the peer counsellors reacted very effectively. They identified individuals who had been close to the deceased, offered defusing and annotated their medical files. Once the immediate issues had been dealt with, the unit evaluated how it had handled the situation to identify what worked and what didn't. The unit also dealt with two attempted suicides, and apparently reacted quickly and sympathetically to each incident.

796 Prior to repatriation, reintegration and stress management briefings were conducted by the chaplain, BPSO and the mental health nurse. These briefings discussed PTSD. A number of peer counsellors were taught how to deliver reintegration briefings in small groups, in their own camps, to their own rank levels. Peer counsellors also set up a system to ensure each member had attended a briefing, and identified soldiers they felt might require assistance in dealing with stress. Each of the soldiers identified by peer counsellors was interviewed by a doctor who discussed stress-related issues. The goal was to deal with any issues immediately and within the unit.

797 On return to Canada, the soldiers were required to return to work for two days, to give them a period away from home to decompress. (Some augmentees, who were anxious to return home, resented the delay.) Social workers apparently arranged stress management sessions for soldiers approximately six to eight weeks after their return from Bosnia.

798 According to several members of the chain of command, the precautions were successful. The chain of command and chaplain informed Ombudsman's investigators that, as far as they are aware, the number of members with stress-related illness after this tour is less than after previous tours. Feedback from soldiers in written questionnaires was apparently positive.

799 The unit chaplain commented, "I think we have done more in this unit than any other unit has ever done in Canadian history to prepare our soldiers for stress." While investigators did not have the opportunity to directly compare the practices of 2 PPCLI with those of other units, I believe that the approach taken by 2 PPCLI is worthy of study by other units.

Summary and recommendations

800 At present, several different professionals have responsibility for screening — social workers, padres, COs and MOs — and, of course, the individual soldier. Frequently, information is not shared among professionals and as a result, problems that could have been avoided surface during a deployment. The MFRC is another valuable resource in dealing with pre- and post-deployment family issues.

801 I therefore recommend that:

14. The Canadian Forces develop a standardized screening process that involves all of the pertinent specialists and that is under the control of a single point of contact.

802 Different approaches to post-operational leave, including decompression and gradual reintegration to normal routine, are possible. The CF must also balance operational requirements against the needs of members and their families. A practical starting point may be to set up a pilot project to determine which approach best meets the needs of all concerned.

803 I therefore recommend that:

15. The Canadian Forces set up a pilot project to determine the most effective ways of allowing members returning from deployment to be reintegrated into family and garrison life.

Part Six: Education for caregivers

804 The health care professionals interviewed acknowledged that the CF is proactive in providing educational and training opportunities for staff involved in the treatment of CF members with PTSD. However, there is always room for improvement. For example, investigators heard that increased demands are being made on base social workers to deal with issues related to PTSD. Not all CF social workers have the depth of training necessary to best treat clients with PTSD. As one base social worker commented:

> 805 Several of my social work colleagues, including myself, do not have the professional skills specific to the treatment of PTSD. This must be addressed. Surely, if the expectation is that PTSD treatment is now part of the CF social work mandate, provision of that clinical training and expertise is essential, via funding from "the top." The requirement and expectation of our troops for effective and efficient treatment of this insidious disorder can be adequately addressed both within garrison and theatre, with fully qualified care providers. I suspect that my current treatment approach differs from my colleagues, thus standardization of care for this issue is lacking.

806 Another base social worker wrote:

> 807 Treatment and diagnosis of PTSD is undergoing constant change and it is difficult to keep up with the ongoing research.

808 Another CF social worker identified the lack of standardized training for social workers about PTSD as a potential issue:

> 809 One problem is that training uniformity is a problem for CF social workers. Almost all initial professional training is done through civilian universities before workers enrol in the CF. After joining the forces most of us do take workshops and special training; however, this is done on an *ad hoc* basis. At present, there is no MOC-specific training courses *per se* on the topic of PTSD. This should be explored. Between universities there are differences in treatment modalities taught. Such training at universities are often electives, therefore we have a wide range of training and experience within the CF social work branch … Most of us have some training, but some have more than others.

810 Another issue, identified by individuals in outlying areas, was the lack of opportunity to meet with other CF health care professionals to discuss treatment of members with PTSD. As noted elsewhere in this report, the OTSSCs are compiling a wealth of expertise in terms of treatment of military-related PTSD, but there appears to be a need to disseminate that information to involved professionals in the field, particularly to those in geographically remote locations.

811 Furthermore, other professionals not directly employed by the OTSSCs, such as base social workers, padres and contract civilian psychologists, have a wealth of experience to offer. Many of the caregivers who met with Ombudsman's investigators suggested opportunities are needed for these professionals to get together to exchange ideas and approaches on PTSD.

812 LCol Matheson, the senior CF social worker, acknowledged the need for continuing education as well as for giving caregivers an opportunity to network and learn from each other's experiences. He told Ombudsman's investigators that:

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> Increased opportunities for education in the area of PSTD and other mental health issues is always welcomed. Training to date has mainly been on an *ad hoc* basis with some social workers receiving considerable training and others receiving only very limited training. Sometimes this is due to funding, other times it relates to opportunities. I am a strong proponent of an annual conference or retreat for several reasons. It is an excellent means to develop a support network system and to foster a sense of comrade[ship], both of which are critical in dealing with the feeling of isolation. Second, it provides the opportunity for an excellent forum for training.

814 The CF health and pastoral care community has now acquired a vast pool of broad-based knowledge about how to treat PTSD. They need to share this information among themselves, with other professionals who work in the field, and with the chain of command. Clearly, the most effective method of sharing information is face-to-face, in an environment exclusively for that purpose. I appreciate that, given increasing workloads, it is almost impossible to get all parties in one place at one time. That said, I believe it is very important that the CF find the resources for training and annual retreats for caregivers.

815 When asked about what education caregivers received, one CF social worker commented:

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> Funding and time always seem to be issues here. All SWOs (military and civilian), chaplains, MOs, NOs [Nursing Officers] and [M]FRC crisis counsellors should have mandated, regular training (similar to the upcoming Family Violence Training — which will hopefully happen this fall) on all the issues we are mandated to address. Apart from CISM training, what training we had on PTSD has mainly come from our own initiative and research and sharing amongst ourselves ... As an SWO, I would like our branch to have an annual conference, to have more regular and standardized training, [and] to have an annual retreat

Summary and recommendations

817 The CF relies on its mental health caregivers as its front line in dealing with members who have, or may have, PTSD. Many of these workers, particularly in the social work field, are also tasked to carry out other functions. To be of maximum effectiveness, all CF caregivers must be adequately trained to deal with PTSD. Further, CF caregivers must have regular access to peers to ensure that they are fully aware of developments and best practices in treating PTSD. In some branches, efforts are already in place; I understand that the Chaplain General hosts an annual retreat for members of that branch. However, the CF social work branch does not currently have such an opportunity.

818 I therefore recommend that:

16. **The Canadian Forces provide sufficient incremental resources to permit all mental health caregivers, including padres and social workers, to access training required to deal with mental health issues.**

17. **The Canadian Forces provide sufficient incremental resources to permit the Canadian Forces social work branch to hold an annual retreat for all Canadian Forces social workers. PTSD should be a significant topic at the retreat.**

Part Seven: Administrative response

Annual leave policy

819 The issue of changing annual leave policy and the resulting confusion is introduced in Part One of this report. In the course of the investigation, several parties speculated that the change in policy, coming as it did just before the incident on 15 March 2001, may have been a factor in what happened. There are frequently unintended consequences of bureaucratic policy changes in a large organization such as DND. Within the CF, the decision to require the use of annual leave in the year that it is earned has had many positive consequences. However, for members on the SPHL, the effect has largely been negative. The system clearly does not have a way of predicting what the impact of such decisions may be on the minority of personnel in special circumstances.

820 For personnel on the SPHL, such changes can cause considerable confusion because of their relative isolation from other members of their unit. A number of PTSD patients referred to the announcement that all annual leave had to be used before sick leave could be granted as "the final insult." Many members on the SPHL are at a stage in their careers when they are planning their transitions to civilian life, and the inclusion of a cash-out from unexpended leave can form a large part of their plans.

821 I am pleased to note that LFWA recognized that this issue was potentially an important factor in Cpl McEachern's case, and, on 19 March 2001, created a 'Tiger Team' to study the issue. The Tiger Team recommended that policy be clarified at the CLS level. Furthermore, the Administrative Investigation into the incident involving Cpl McEachern on 15 March conducted by LFWA recommended that the leave policy be clarified and persons on the SPHL be provided with sufficient warning:

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> The leave policy must be clarified and promulgated to all personnel ... there must be follow up to ensure that the information is passed to soldiers either through the newspapers or at routine unit briefings ... Policy must be promulgated at the start of the leave year and all personnel briefed on the requirement, to expend their annual leave, when placed on SPHL.

823 In other words, annual leave policy must be clearly understood by all personnel, including those in the chain of command. When changes are necessary, they must be introduced sufficiently early in

the leave year that members can adjust their plans accordingly. Leaving major adjustments until the last few weeks of the leave year creates unnecessary stress and avoidable pressure.

Occupational transfer

824 Cpl McEachern stated that, when he was told at the time he was going off the SPHL that he would have to go back to his unit and serve in the combat arms, he felt he had no choice but to quit. He felt he had "been completely humiliated" and could not go back to his unit. Many soldiers on the SPHL or released from the CF because of PTSD to whom Ombudsman's investigators spoke would, like Cpl McEachern, have preferred to muster in another MOC rather than return to their original unit and MOC or be released.[14]

825 LCdr Greg Passey, now a civilian psychiatrist practising in Vancouver, served for 22 years in the military and has extensive experience in treating PTSD. Recognized in Canada as an expert in this field, he continues to contribute to the treatment of PTSD. LCdr Passey, as Cpl McEachern's original psychiatrist, believes that the plan he had established for Cpl McEachern would have helped him to recover from PTSD to the point where he could have functioned effectively in another MOC. The decision not to proceed with this plan for an OT was taken after LCdr Passey retired. He feels it was denied on the grounds that it violated the rules about voluntary OT.

826 When interviewed by Ombudsman's investigators, LCdr Passey described the context in which he recommended that Cpl McEachern be given an OT and his concerns about the policy surrounding OT:

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> McEachern is a prime example of someone that never needed to be where he's at. I asked way back that we institute a policy wherein if a person has a significant — in this case I was focused on PTSD — if they had significant PTSD and it was highly unlikely they would ever go back to their original MOC and that it looked amenable to treatment and that they could probably deploy in a different MOC, I would ask

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[14] See Part One of this report for extracts from correspondence relating to an Occupational Transfer for Cpl McEachern.

> the military to implement a policy where they be given preferential reclassification ... If Chris [Cpl McEachern] had been able to do that, you wouldn't have heard anything more. It would have given him a way of re-establishing his self-esteem and respect. The only thing he ever wanted to be was a soldier ... His image was this tough soldier. This has destroyed him.

828 LCdr Passey did not believe that Cpl McEachern was the only soldier caught in this bureaucratic trap. Ombudsman's investigators interviewed another infanteer in Edmonton, referred to them by LCdr Passey, and confirmed that his request for an OT had suffered the same fate as Cpl McEachern's. After describing the situation of these two soldiers and based on his previous military experience, LCdr Passey concluded, "Both these guys were, in my estimation, excellent soldiers. If you put them into a place where they could be allowed to work, they would have been excellent soldiers, whatever they happened to be. We didn't give them that chance."

829 Although the infanteer above has completed numerous courses (military and civilian) to qualify as a tradesman, he has not been allowed to take an OT out of the combat arms MOC. As a result, he will eventually be released as medically unfit, and all of the experience he has garnered will be lost to the CF. An Ombudsman's investigator is now handling his complaint.

830 The Croatia BOI recommended that the CF tailor "a standard and flexible process for all military occupations to accommodate personnel who can still be gainfully employed" (Recommendation 12). As of mid-July 2001, it was reported that some progress had been made on this issue. CANFORGEN 011/00, issued 19 January 2000, announced amendments to the Universality of Service policy introducing more flexibility in the employment of personnel. Administrative review decisions from 30 June 1999 to 18 January 2000 (242 cases) will be reviewed based on the new standards. However, as of 31 March 2001, there were still 900 files awaiting administrative review.

831 The Director General of Military Careers, BGen Jean Leclerc, pointed out to Ombudsman's investigators that there is a difference between voluntary and compulsory OT. His staff deals with members who are given permanent medical categories below that of their own MOC but still within those of other MOCs. These members are normally offered transfers to more than one choice of trade. However, members assigned temporary medical categories (the category most PTSD patients are assigned initially) are managed by the recruiting, education and training part of the CF, along with all other serving members requesting a trade transfer. My investigators were informed by Capt R. Stevens, a staff officer in the CF Recruiting Group Headquarters (CFRG HQ) that:

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> If an in-service member applies for Voluntary OT and he/she has Medical Employment Limitations, DMCARM [Director Military Careers Administration and Resource Management] would ultimately decide whether the individual would be employable in their desired MOC. CFRG HQ ISS&S [In-Service Selection and Security] will not normally process a member for Voluntary OT if they are on a Temporary Medical Cat, unless it is highly likely that that the Temp Cat would be lifted prior to the start of training in the MOC for which they are selected.

833 The perception is that, if a member with a medical limitation related to PTSD were given priority, it would be tantamount to "jumping the queue."

834 The bureaucracy has also failed, in other instances, to respond in a timely manner to personnel with psychological disabilities. A clinical psychologist in a large urban centre described a situation in which a serving member with PTSD was deteriorating in his current employment. The psychologist recommended an immediate transfer to another job. In her words:

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> I made recommendations about this man at least two months ago. He needs to be moved out of his position. He has become more and more volatile in the last few weeks because they still haven't told him what is going to be happening. The military are notorious for asking for recommendations and then not following through on them right away ... There should be some way of fast-tracking things through, particularly when it is a medical condition case.

836 There is ample evidence indicating that Cpl McEachern had developed into an above-average soldier and was considered to have high potential to advance in rank within his infantry career. A review of his personnel and medical files suggests that he was a good soldier who experienced a traumatic event or events that eventually began to affect his performance and attitude. Cpl McEachern's desire was to be a soldier. Cpl McEachern's situation today represents a failure of various CF authorities to retain an injured soldier who was salvageable. It is possible that Cpl McEachern could have been salvaged through the simple action of moving him into another occupation that permitted a lower medical category. Although his highly qualified medical caregiver recommended that action, it never took place.[15]

Transitioning soldiers off the SPHL (fit for release)

837 Ensuring CF members with PTSD are "fit for release" is of critical importance. Members on the SPHL are in a transitional period, whether the transition is back into military employment or to release, and they need help through this transition. Moreover, the CF needs to make keeping members within the military a priority. The MOs we interviewed indicated that many PTSD sufferers are successfully returned to their trade or to a new trade, and even redeployed after having received treatment for PTSD.

838 The Croatia BOI recommended the CF institute "a seamless and continuous 'Fit for Release' process for all releases — both Regular and Reserve" (Recommendation 13). The concept of "fit for release" is based on the same concept the CF uses for enrolment: just as members are not accepted into the CF unless they are physically and mentally fit to serve, members must be physically and psychologically ready for release; if specific physical or psychological treatments are needed for members to make that transition, then they must be completed before such members leave the CF.

839 The Fit For Release Working Group formed to recommend specific revisions to the release system has identified many of the shortfalls in the current system. Based on the working group's report, a draft plan was submitted to COS ADM (HR-Mil) in March 2001 and

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[15] As noted throughout this report, Cpl McEachern is not seeking specific personal redress for the manner in which he was treated by the CF. With respect to the issue of Occupational Transfer, he advised my lead investigator that he did not wish to pursue the matter of the CF's failure to occupationally transfer him when it had the opportunity. He stated that he was content that the issue of OT would be addressed on a systemic basis in this report.

DCSA is now drafting a paper for ADM (HR-Mil). The report recommended an action plan be implemented to facilitate the transition from military to civilian life for those being medically released. This initiative is very complex and will take more time than originally expected. DCSA now expects an approved plan to be implemented by December 2001.

840 The establishment of a dedicated project team will be required. An important part of the initiative is the CF Transition Assistance Program (TAP). According to the update to the CDS, dated 13 July 2001, the TAP program has over 200 resumés on file and a potential client base of over 1,000 medically released members coming off vocational rehabilitation training who will be looking for work. To meet the anticipated increased demand for TAP services, TAP is exploring the involvement of the public and private sectors; for example, TAP is working with VAC on a CF employment equity program and on a hiring program for injured and medically released personnel with the Public Service of Newfoundland. In accordance with the fit for release concept for medically released personnel, CF members with PTSD should not be prematurely released from the CF, but should be assisted to make the transition back into the CF or to be physically and psychologically prepared for release.

841 Overall, I believe that the CF is committed to improving the fit for release process and I fully support the CF in the positive initiatives it is taking in this area.

Summary and recommendation

842 Given the current focus on retention and recruitment in the CF, along with the costs of attracting and training new members, it would appear to be in the best interests of all involved that the CF be as flexible as possible when considering the merits of OTs for members who have been diagnosed with PTSD. The vast majority of those with PTSD who were interviewed by Ombudsman's investigators had been assessed by their units as good to excellent soldiers. On the face of it, there appears to be no reason why soldiers who clearly have a great deal to offer cannot be gainfully employed somewhere within the CF.

843 It has been argued that allowing voluntary OTs to members diagnosed with PTSD may create an unhealthy precedent, inferring that others might feign the symptoms of PTSD to obtain an OT. In my view, that argument holds no merit. As analysed in detail in this report, the consequences to members of having PTSD are so negative, it defies belief that any person would voluntarily subject themselves to such consequences merely to transfer jobs. Furthermore, the Code of Service Discipline contains adequate provisions to deal with any proven abuse of the system.

844 I therefore recommend that:

18. The rules regarding Occupational Transfer be changed to quickly accommodate members diagnosed with PTSD who would benefit therapeutically from working in another military occupation.

Part Eight: Systemic issues

845 In the course of this investigation, the investigative team found that Cpl McEachern's circumstances were not unique. Many other CF soldiers who had experienced similar problems approached the investigative team to volunteer information. Ombudsman's investigators were also advised of issues relating to PTSD that Cpl McEachern did not complain of directly. As a result, they examined a range of issues that appear to be systemic in nature.

Treatment of Reservists and augmentees

846 Since Cpl McEachern's initial experience on deployment with the CF was as a Reservist,[16] Ombudsman's investigators looked closely at these CF members, and at Regular Force augmentees of deployed CF units.

847 Many sources maintained that augmentees (either Reservists or Regular Force personnel that augment BGs) are particularly vulnerable to PTSD. This vulnerability may be as a result of lack of a peer group that experienced the same deployment, and for Reservists, lack of social interactions with peers enjoyed by Regular Force members. Historically, because Reserve Force personnel and augmentees were not part of the unit, they often received inadequate debriefings and follow-up was non-existent. However, it should be noted that significant improvements have recently been made in the process for briefing and debriefing Reserve Force members and augmentees, although considerable work remains to be done.

848 Reserve Force members can form a significant proportion of deployed contingents; for instance, Reserves can form as much as 20 percent of a BG. In some integral units, Reserve members can outnumber Regular Force members. Ombudsman's investigators were told of a rifle company in Roto 2 of Op Harmony in Croatia in 1994 that had 85 Reservists of a total of 135 personnel. With the current personnel shortages in the CF, and the fast pace of operations, the trend is likely to continue. In fact, there are plans to deploy a formed rifle company comprising only Reserve members in upcoming Roto 11.

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[16] The terms Reservist, Reserve Force member and Reserve are used interchangeably throughout this report.

849 One of Cpl McEachern's complaints was that he was discriminated against because he was a former Reserve member, alleging that it is a systemic issue because Regular Force members do not accept Reserve members as part of the team. I will not deal with that issue specifically in this report; however, as this investigation progressed, it unearthed some evidence that some in the system see Reserves as second-class citizens and that there is significant friction between Regular Force members and Reservists that may extend to the provision of care for those diagnosed with PTSD. A very senior officer from the Reserve component related an incident in which a Reserve Force member was diagnosed with PTSD and attempted suicide on several occasions. According to the senior officer, when the Reservist's CO sought help for him, he was told, "Fuck him. He's a Reservist. He kills himself, who cares?" One hopes this is not a typical response.

850 The same senior officer advised Ombudsman's investigators that any discrimination that may exist in the CF certainly does not carry over into VAC:

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> As far as Veterans Affairs is concerned, a veteran is a veteran. Whether the individual is a Regular Force soldier or a Reserve soldier, they don't really care. If they have a problem, their attitude is they want to help them. I find Veterans Affairs has a very positive attitude toward this.

852 A senior Reservist serving in the CF medical system provided another perspective:

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> If we don't solve at the end of the day who is paying for what, if we don't stop saying whose bloody budget is it coming out of, we are never going to solve this problem. If we can't stop saying ... CF and just mean the Regular Force — because it isn't. We all wear a uniform. I take exception to not being called a member of the Canadian Forces, because I am.

854 Because Reservists are often added to a deploying unit piecemeal, they may have a sense of isolation and 'being different' within the unit. Ombudsman's investigators heard of Reservists being discriminated against by Regular Force members based on a perception that their qualifications were not as good. In deployments, soldiers are required to work together in close-knit teams, difficult to achieve when Reservists are not considered equals in terms of qualifications and abilities. Being subjected to high-intensity operations without being a fully integrated member of the team cannot help but increase stress and thus susceptibility to serious psychological consequences such as PTSD.

855 It is worth noting again that effective deployment-related training and debriefing procedures are particularly important for the well-being of Reserves and augmentees. Personnel who augment BGs are equally at risk of being overlooked in the post-deployment phase. Returning to their home units can involve negative experiences such as being considered to have been "on vacation." Ombudsman's investigators heard considerable anecdotal evidence that medical personnel who are attached to deploying units are particularly apt to be "left on their own" without a support network. Reservists and augmentees are also at risk of falling through the cracks on return from deployments because they do not have a peer group to talk to about shared experiences. The Deputy Commander of LFWA, BGen Dennis Tabbernor, has experienced this personally. In his words:

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> One would think that a soldier, regardless of their background, arriving back in country is dealt with the same as any other soldier regardless of whether they are augmentees, Regular or Reserve. In some ways, I think we pay lip service to the things that we say we are doing ... So it still goes on, regardless of what we say and what we do, and yet we are in 2001 and it shouldn't be happening, but it still does ... When we come home, everybody seems to be in a haste to either send the augmentees home, get off on leave, and get back to a normal life, and perhaps some of the things we say we do or should be doing we don't do as well as we should.

857 The effects of lack of mutual support should not be underestimated. Most personnel Ombudsman's investigators talked to identified the importance of a supportive group of members from a specific tour to an individual's ability to deal with post-deployment stress. On at least one occasion, Reservists and augmentees were reported not to have even been included in welcome-home activities. One Reservist investigators talked to reported that those affected greatly resented being excluded.

858 Since the effects of PTSD are not often evident until several months after a deployment, it is essential that contact with these members be maintained. There is a perception, even within the Regular Force, that the organization has not done enough to ensure that Reserve members and augmentees are followed up appropriately. As one senior officer with 30 years' experience told Ombudsman's investigators:

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> The Reserve guys come back off deployment and are waved goodbye. No serious attempts to properly debrief them. The CF tells them to call the Padre if they want. They go back to their units and many of them quit. There are a bunch of walking time bombs out there.

860 However, as noted in Part Five of this report, various Land Force Areas are making considerable efforts to remedy this problem. Deployment-related directives acknowledge the need for follow-up with Reservists and augmentees and create procedures designed to ensure that this is done.

861 In terms of responsibility for maintaining contact with augmentees, the deployed unit should retain the mandate for conducting follow-up contact. Regardless of whether the augmentee's unit is Regular or Reserve Force, units that have little or no understanding of the particular deployment may have difficulty providing the support needed and will have no credibility with the soldiers.

The MPHL/SPHL

862 The MPHL, recently revamped and renamed the SPHL, allows units to assign replacements for members who are either temporarily (six months or more) or permanently unable to perform their normal duties for medical reasons. Members may eventually be directly released from the military from the SPHL, or they may be transferred from the SPHL back to normal duties if their medical condition improves sufficiently.

863 When the SPHL (then the MPHL) in Edmonton was created in November 1998, three members were posted to it. That number rose to 23 members by January 2000 and 42 members by February 2001, with 22 members waiting to be posted to the SPHL. As this investigation draws to a close (fall 2001), there are approximately 120 members on the SPHL in Edmonton.

864 Many soldiers see the SPHL more as part of the release process than as a stepping stone to returning to full duties in the CF. This perception would appear to be borne out by statistics from the Edmonton/ASU SPHL. As of February 2001, only two members who had been posted to that SPHL had subsequently returned to full duty. The most common result of being posted to an SPHL is medical release from serving in the CF.

Transition from the MPHL to the SPHL

865 The Report of the Standing Committee on National Defence and Veterans Affairs (SCONDVA) on Quality of Life in the CF in March 1999 and the McLellan Report on the Care of Injured Personnel and Their Families in November 1997 both recommended that the policies governing the reporting of injuries and medical conditions be reviewed, including the MPHL. Their main concern was that the centralized MPHL caused the member's connection with the unit to be severed when he or she was posted to the holding list.

866 This led to CANFORGEN 017/00, promulgated in 2000, which directed that the centralized holding list known as the MPHL become the decentralized SPHL. That CANFORGEN was superseded later that year by CANFORGEN 100/00. One of the primary concepts behind the creation of the SPHLs was to provide as much support for the member as possible.

867 Ombudsman's investigators heard some positive comments about the creation of the SPHL from the CF medical community. The DGHS, BGen Lise Mathieu, stated that "the creation of the SPHL is an indication that we have moved along — it goes toward saying an unfit person is the responsibility of the CF rather than shifting the responsibility to another agency."

Centralized vs. decentralized SPHL

868 Management of the SPHL varies across the CF, reflecting local priorities. In some areas, the centralized approach is used; in others, a decentralized, unit-focused approach is in place. Regardless of which approach is used, there appears to be considerable dissatisfaction with the centralized SPHL approach in meeting the needs of the CF and members with PTSD.

869 The following is a brief examination of the benefits and drawbacks of the centralized approach to dealing with injured personnel as opposed to the decentralized approach. In the centralized approach, the unit is no longer responsible for the individual; rather, the central agency administers, employs and cares for the individual. In Cpl McEachern's case, he was transferred from 1 PPCLI to the ASU at Edmonton. (ASU Edmonton continues to follow a centralized approach to the SPHL as opposed to the decentralization envisioned in the CANFORGEN.) In the decentralized approach, an individual's unit retains overall responsibility. Neither approach precludes the involvement of either the unit or a central agency in the treatment of an individual, but the all-important perception of 'ownership' of responsibility toward the individual member does change.

870 In brief, the following are the positive aspects of the centralized approach reported to Ombudsman's investigators during this investigation:

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- It relieves the unit CO of the responsibility of doing the day-to-day administration of those on the SPHL, allowing him or her to focus on training and operations within a unit.

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- It permits members with significant health issues to see that they are not alone.

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- Units are not as familiar with mental health issues or as knowledgeable about the resources and entitlements available to members as a single organization is. Members with psychiatric problems can require a great deal of support, and particularly need the specialized expertise available centrally.

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- In theory, the centralized approach ensures that members are properly referred to medical authorities, social workers and back-to-work programs.

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- It facilitates the cohesion and co-ordination of services for individuals by acting as a central point of contact.

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- It ensures a common standard of how those on the list are treated, as opposed to differing standards among units.

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- It ensures that members do not fall through the cracks and are closely monitored.

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- It ensures that paperwork is properly processed and members are kept up to date on administrative changes.

879
- It allows the unit to request a replacement so that the unit's ability to perform its mission is not impaired.

880 Some criticisms of the centralized approach that Ombudsman's investigators heard are listed below:

881 • The base, not the unit, administers members. As a result, those on the SPHL feel that they have been "forgotten," "abandoned," "cut adrift" and "ostracized" by their units.

882 • One of the goals of switching from the centralized MPHL to the decentralized SPHL was to encourage contact between the member and the unit and maintain trust in the unit's desire to look after its members. Soldiers consistently complain of having no further contact from their units once transferred to a centralized SPHL.

883 • Losing that contact with the unit may constrain a soldier's best chances of returning to full duties. The unit can also continue to employ the soldier part-time, perhaps in a different capacity, such as in administrative work or canteen duties, so that the soldier still feels welcome and beneficially employed within the unit.

884 There is some debate in the CF caregiving community about the benefits of a centralized SPHL. A CF social worker summed up the views many expressed about whether a centralized approach is an effective method of dealing with members diagnosed with PTSD:

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> I think there are problems [with placing members with PTSD on the SPHL] ... I have seen people completely away from work for months, which in the long term is not a solution. It is not consistent with the philosophy of critical incident stress management whereby people are debriefed, defused and rested as close to the scene of operation as possible. Research shows that these people have a better prognosis for quick and comfortable return to duty. It is when people are taken completely away from work that they become marginalized and isolated, and have a more difficult time returning to work. SPHL as it has been sometimes used has a tendency to reinforce the notion that they are somehow broken, sick or inadequate. A better way would be for people to have a shorter rest time away from work if at all, followed by duties in a less stressful job but near to their peers. This would of course have to include education for all to maximize the sense of buy-in and support from peers who are doing the demanding work while their buddies are on light duties. This includes more recognition of psychological injuries as *bona fide* injuries. A video format with self-testimony would be helpful in this area. It is very healing for people to feel part of the organization and that they can continue to make a

> contribution, even though they are out of the 'line of fire' for a spell. The workplace has tremendous benefits for healing support.

886 The SPHL in Edmonton was centralized to relieve COs of the burden of administering the SPHL, given the high numbers in Edmonton, and to provide the best quality of support possible. Ombudsman's investigators heard nothing but praise for Capt Tizzard, the OC the Edmonton/ASU SPHL, from both her chain of command and those on the SPHL to whom they spoke. Some initiatives to improve the SPHL at Edmonton are to be applauded; for example, LFWA has recognized that the SPHL needs increased resources to meet the rapidly increasing caseload (from three members on the SPHL in late 1998 to over a hundred to date) and is in the process of providing them. Increased efforts are being made to enhance regular communication between those on the SPHL and those responsible for administering it. That said, many of those on the SPHL, including Cpl McEachern, felt that they had been placed on the SPHL because their units considered them a burden and wanted to get rid of them.

887 Many individuals interviewed suggested that there be as flexible a policy as possible for whether a member is placed on a centralized SPHL or an SPHL within the unit, since some members benefit most from being on a centralized SPHL on a base, while others are better off in their units. Most parties thought it far better, in principle, that members stay as close to their units as possible. However, according to various sources, COs have an incentive to place individuals on the SPHL so they can obtain a replacement for an injured or ill member. This requirement obviously places COs in an undesirable position, forced to choose between keeping their units at strength and maintaining responsibility for their troops. Clearly, a more flexible policy, with input from all parties including the soldier being placed on the SPHL, is called for.

Circumstances under which a member is placed on the SPHL

888 Normally, three categories of Regular Force personnel can be placed on the SPHL. They are:

889 1. Personnel on retirement leave who are hospitalized or on sick leave and require an extension to service.

890 2. Personnel who have significant employment restrictions for medical reasons for six months or more; and

891 3. Personnel who have been given a medical release date and who have been authorized to participate in full vocational rehabilitation training.

892 Article 5 of CANFORGEN 100/00 specifies that a member who has become medically unfit with significant Medical Employment Limitations for six months or more may be placed on the SPHL if the CO considers a replacement essential.

893 Paragraph 5.B.(2) of CANFORGEN 100/00 states: "The HCC [Health Care Co-ordinator] will inform the CO of the member's employment limitations, including information on when or if the member is likely to be returned to full duty without limitations."

894 The CO must initiate the process to place a member on the SPHL and forward the application to the appropriate Career Manager. If the CO wishes to post the member to the SPHL at a location other than the home unit, the CO must provide the Career Manager with reasons.

Role of the Career Manager

895 Paragraph 5.B.(3) specifies the duties of the Career Manager as follows:

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> On receipt of the application the Career Manager shall post the member to the SPHL at a location where treatment can be continued and normal administrative services are provided. Such factors as geographical location (for example outside Canada), availability of appropriate medical care (military or civilian) and the requirement for relocation with immediate or extended family will be taken into account. In the absence of compelling reason and where no change in geographic location is required the member should be posted to the SPHL at his or her home unit or a designated RSU. *In all cases the best interests of the member shall prevail* [emphasis added]. DCSA will be included as an action addressee on the SPHL posting message. The Career Manager will post in a replacement as soon as possible IAW [in accordance with] CF manning priorities and personnel availability.

897 Paragraph 5.D specifies that a member will be removed from the SPHL after the Health Care Co-ordinator (HCC) has advised the unit that the member is fit for duty without significant limitations.

At that point, "The unit CO will notify the appropriate Career Manager who will post the member to a suitable position."

898 A number of CF members to whom Ombudsman's investigators spoke suggested that Career Managers sometimes refuse or delay a CO's request for soldiers to be placed on the SPHL because of pressures of operational requirements, shortage of personnel and budgetary limitations on moving expenses. In fact, a senior NCM indicated to investigators that the system is broken: he understands that some Career Managers use quotas that allow only a fixed number of personnel from a specific MOC to be on the SPHL at the same time, often because of lack of personnel to replace them.

Maintaining responsibility for the member on the SPHL

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> ... they had asked the focus group of COs across the country when somebody isn't fit, whose responsibility is he? And ... half the people said that he was the responsibility of the Surgeon General ... and the other about 30 percent said he was the responsibility of someone else, they didn't know who, but only 20 percent said he's my responsibility.
>
> DGHS

900 As noted in Part Three of this report, support from a member's unit is an issue of particular concern to members diagnosed with PTSD.

901 One of Cpl McEachern's primary complaints involved lack of support from his unit, epitomized by the unit's failure to maintain contact with him while he was on the SPHL. He stated that he did not hear from anyone in authority at 1 PPCLI from the point when he was posted to the SPHL, other than from a Master Corporal from his company who called to see how he was doing. He identified lack of support as a serious issue:

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> That is the problem. One would expect the unit would at least say 'good luck with your recovery' and we will keep in contact to make sure you are doing well, etc. ... From my chain of command, nothing.

903 Cpl McEachern described his sense of betrayal when support from his unit was lacking as follows:

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> ... the whole regimental system is based on support in the family environment for its soldiers going through difficult times and a lot of times when the soldiers

> come out of the difficult environments, that's what they fall on, is the regimental system, the regimental honour, you know, the flag, the guys that die for the flag, the honour. Okay, we know you're sick, we're going to take care of you — none of that's here. There's no sense of regimental family at all anymore, it's everyone's out for himself and get over with what you can …

905 He indicated that he believed his recovery from PTSD would have benefited from any signs of support or symbolic gestures of appreciation for his military service:

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> … that's where the unit support comes in. You know, the PTSD … I believe it's manageable but when the troops are made to feel completely humiliated and ostracized from their unit, you just … I put all this work in trying to be a good soldier and you know I just felt completely humiliated when all I wanted was a pat on the back saying 'good job, thanks for coming out,' you know, 'thanks for serving the regiment,' 'you were a good soldier' and you know, like … we're not asking for much.

907 As a solution to the problem, Cpl McEachern suggested that:

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> … there needs to be a genuine liaison between the regiment and the SPHL such as a Platoon Commander or a Captain. They genuinely care about the welfare of his troops that has a connection back to the regiment and if there's any awards or if there's anything that needs to be taken care of it's done at the regimental level, you're still feeling like you're part of the regimental family.

909 An Ombudsman's investigator spoke to an officer at 1 PPCLI who was partially responsible for maintaining contact with unit members at the time Cpl McEachern was posted to the MPHL/SPHL. The officer indicated that, at the time Cpl McEachern was placed on the MPHL/SPHL, the unit was perhaps not as assiduous as it should have been in maintaining contact with members. However, the officer pointed out that members on the SPHL sometimes do not want to be contacted by their units. In some instances, a member's caregiver had indicated that contact with the unit would be detrimental to recovery. This officer felt that the unit was caught between "a rock and a hard place" when determining whether to call a member on the SPHL. His view was shared by many others within the chain of command to whom investigators spoke.

910 This officer advised that the unit is now much more conscious of the importance of contacting members on the SPHL who want to be contacted regularly. The assistant adjutant is responsible for contacting such members monthly by phone to update them on what is happening in the unit and to see if they need anything. Indeed, 1 PPCLI has been particularly proactive in that regard. The recently appointed CO has created a 'welfare NCM' position whose duties include keeping in regular contact with members on both the unit and centralized SPHL. This welcome development appears to be the right direction; it would be beneficial to monitor how effective it is in practice.

911 The LFWA Administrative Investigation[17] into the incident involving Cpl McEachern found that "all SPHL members" at the CFB Edmonton SPHL felt there was a lack of contact by their units. It made the following recommendation:

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> Regular Unit Contact. Many personnel on the SPHL feel abandoned by their units because of the lack of regular contact and negative feelings built up over the years. CANFORGEN 100/00 directs units to appoint a formal point of contact for the unit and to maintain regular contact with personnel on SPHL outside the unit. The implementation of this direction is dependent on personalities, workload and the passage of time.

913 LCdr Passey had extensive dealings with soldiers and units in Edmonton that employed the MPHL/SPHL to deal with PTSD patients during his service in the CF. When asked to comment on the effectiveness of this approach, he also expressed concerns that units tended to abandon members referred to the SPHL:

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> ... there is an attitude problem with the front line battalions and regiments. They label you and they want to shuffle you into this SPHL. Once they do that, they brush their hands. They don't phone, they don't follow up. It's like you are a pariah and you are out of there and that's it. There is a real problem there.

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[17] Administrative Investigation — Contributing Factors to Actions of Cpl C J McEachern.

915 The issue of to what degree units should accept responsibility for members who are on the SPHL has yet to be resolved even among COs. CANFORGEN 100/00 provides that:

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> If the member is placed on the SPHL at his/her home unit, normal unit support procedures apply. Should the member be posted to the SPHL at another unit the losing unit CO shall designate a sponsor from his/her unit or deployment support group (rear party). The sponsor shall be senior enough to provide advice and assistance, maintain regular contact with the member and ensure the member is kept informed of unit activities. DCSA will provide assistance to unit, member and sponsor where required. (5.C. Support)

917 Regardless of the intent of CANFORGEN 100/00, it appears that some units are not being as diligent as they should in keeping in contact with their members on the SPHL. This may be related to a lack of clarity as to who is responsible for members on the SPHL. According to the passage quoted above, by BGen Lise Mathieu, DGHS, a focus group of COs across the country conducted for CRS showed that half believed that members on the SPHL were the responsibility of the Surgeon General, while about 30 percent believed they were someone else's responsibility, and only 20 percent of the COs accepted responsibility.

918 This succinctly describes a fundamental issue that has to be resolved; who is responsible for the sick soldier? The CF teaches leaders that the welfare of their troops is a fundamental responsibility of leadership. Nonetheless, the issue of responsibility for personnel on the SPHL would seem to be a major point requiring clarification within the organization.

919 As a senior MO at NDHQ observed:

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> SPHL is better than MPHL. MPHL was bad because the unit sloughed it off ... There are certain places where they are making local arrangements, where they are dumping them back on the base again which is the wrong answer ... They are circumventing the way the system was set up because they don't want the responsibility.

921 The issue of contact with members on the SPHL has also been recognized by LFWA. A draft CFB Edmonton Garrison Standing

Order entitled "Care of Injured or Ill Service Personnel and Service Personnel Holding List," dated January 2001, notes that:

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> It is essential in most cases that a member placed on ASU Edm SPHL has ongoing support and contact with their former unit. During the transition from the unit to ASU Edm SPHL, an agreement between the SPHL Platoon Commander and the unit will be made to ensure regular contact with the member and to ensure the unit receives regular updates on the member's status.

923 During the course of this investigation, frequent reference was made to the fact that excessive workloads at the unit level have a detrimental effect on a unit's ability to support members on the SPHL. In short, COs simply do not have the time or resources to look after members on SPHL as well as they might. COs indicated that operational tempo is so fast-paced, units have "their foot to the floor," as it were. New responsibilities are added without additional resources. Furthermore, many units are considerably under-authorized establishment, which leads to fewer people doing the same or more work. These constraints, as well as leave and training commitments, seriously detract from a unit's ability to properly look after its ill or injured members. In summary, the press of other responsibilities appears to be reducing units' ability to maintain contact with their members once they are no longer able to contribute to the effectiveness of the unit.

924 A unit should be required to make every effort to maintain regular contact with its members who are on the SPHL. While some members on the SPHL prefer to have no contact with the unit, most members to whom Ombudsman's investigators talked interpreted lack of contact as a sign that they had been abandoned or thrown away because they were no longer useful. The unit has an obligation to look after its own. In my view, this is an overriding obligation and contact should not be dependent on "personalities, workload and the passage of time," as noted in the LFWA Administrative Investigation.

925 There is clearly a breakdown in communication among units, caregivers and members on the SPHL in too many instances. Although there is no 'one size fits all' solution and this direction should be flexible enough to permit an assessment of what is best on a case-by-case basis, the onus should be on the unit to establish whatever level of contact the member on the SPHL is comfortable with. CANFORGEN 100/00 directed that units continue to have regular contact with members on the SPHL. However, the policy does not define 'regular contact.' I believe that, subject to any restrictions imposed by a member's caregiver, units should contact members on the SPHL at least every two weeks. CANFORGEN 100/00 also directed that units ensure that members on the SPHL be informed of unit activities. Further, I believe that every effort should be made to include such members in unit activities, again subject to any restrictions imposed by the member's caregiver.

OTSSCs

926 As noted in Part Six of this report, there is considerable anecdotal evidence from CF members that the OTSSCs are doing an excellent job of providing care for members who seek their services. There is also significant anecdotal evidence that there are resource, structural and procedural issues relating to the operation of OTSSCs that must be addressed.

927 Five OTSSCs were established under the Quality of Life initiative in the fall of 1999; centres in Halifax, Valcartier, Ottawa, Edmonton and Esquimalt complement the existing network of health care facilities. Their mission is to develop a body of expertise and experience in the management of psychological, emotional and spiritual needs of CF personnel arising from military operations. The centres provide assistance to serving members of the CF and their families who are dealing with operational trauma and stress arising from military operations, particularly from UN and NATO deployments abroad. The OTSSCs employ a multidisciplinary team consisting of both military and civilian health care professionals — psychiatrists, psychologists, social workers, chaplains and community health nurses.

928 Among the individuals Ombudsman's investigators interviewed, including civilian and military medical personnel, there is strong agreement that OTSSC caregivers are doing an outstanding job despite being considerably short-staffed and overworked. Members being treated for PTSD at the OTSSCs consistently reported that they were receiving wonderful care from OTSSC caregivers, who "bent over backwards" to help patients. Similarly, the support groups set up by some OTSSCs are reported to be a great innovation that is doing a tremendous amount of good.

Co-ordination among OTSSCs

929 Of the three OTSSCs consulted during this investigation — Valcartier, Edmonton and Halifax — there was no agreed-upon "best method" of treatment. Rather, a multiplicity of treatments for PTSD is available within the CF Health Services, as within the Canadian medical community at large.

930 Arguably, there are benefits to exploring various avenues of treatment. However, from the mobile military patient's perspective, it means that there is a potential for different treatments across the country and possibly for the same patient. Aside from the impact on patients, the diversity of approaches makes the collection and analysis of information about the efficacy of treatment more difficult.

931 The lack of co-ordination among the five existing OTSSCs in Canada is of concern to the CF medical system. Indeed, CF caregivers have expressed doubt about the lack of consistency of diagnosis for PTSD at the different OTSSCs, despite the criteria laid down in the DSM-IV. According to a senior staff officer in the medical chain of command:

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> Right now they [the OTSSCs] are not standardized. *Point final* — they are not. They were meant to be; they were set up to be that way, but it has evolved not to be. As part of mental health reform, we are bringing the OTSSCs along that way … It is evolving, and the whole timeline to having an integrated approach to mental health delivery in the Canadian Forces … is to have an integrated approach to that by the year 2003 or 2004.

933 The following comment by a CF health care provider points out the danger of lack of standardization and co-ordination:

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> Treatment and diagnosis of this mental health problem is undergoing constant change and it is difficult to keep up to the ongoing research. The growth of the system around CIS and PTSD that is responding to this problem has led to some treatments that are not very well researched and that could potentially prove to be ineffective. Until this research is available, our response will be well intentioned but not always satisfactory.

935 At the Operational Stress Injury Social Support (OSISS) working group session in Petawawa on 23 August 2001, Col Boddam, the senior CF psychiatrist, described five major initiatives under way to standardize the OTSSCs:

- **936** to develop a uniform assessment procedure;
- **937** to develop a uniform approach to treatment;
- **938** to develop a uniform set of outcome measures;
- **939** to develop a uniform series of outreach programs and education to satellite clinics; and
- **940** to develop a uniform approach to research needs.

941 While the autonomy of local caregivers to treat PTSD in accordance with the DSM-IV must be respected, standardization of OTSSCs is overdue.

Providing OTSSCs with stable funding

942 Based on information from both NDHQ medical staff and the OTSSCs, Ombudsman's investigators understand there has been a change in the OTSSC funding process effective for this year's business planning cycle. Previously, funding for OTSSCs was controlled and allocated from NDHQ, specifically from the office of the Assistant Chief of Staff, Health Services Delivery. Now that funding has been devolved down to the HCC at each site, there is some danger that OTSSC funding and dealing with PTSD may lose priority: therefore dealing with PTSD through the OTSSCs may lose priority. The health care system does not have excess resources either locally or nationally. If the HCC has a number of pressing local demands that have more direct operational impact, the competition for these scarce resources will be stiff. It might well be advisable to treat OTSSCs as national units and retain the funding authority at NDHQ.

943 The ability to develop plans on the basis of a stable, multi-year budget is very important to OTSSCs. Co-ordinating support within the civilian community, developing long-term relationships with civilian caregivers, and attracting and retaining qualified professionals, so essential to the OTSSCs' effectiveness, all suffer if budgets vary from year to year as a result of shifting priorities at the HCC level. Furthermore, since the OTSSCs are response-driven (i.e., activities are driven by the number of patients) and costs are not within the control of the OTSSCs, flexibility must be built into budgets to allow for fluctuations.

944 Continuity of caregivers is also an issue. Cpl McEachern indicated the change in psychiatrists caused him concern; in his case, the change was as a result of the retirement of his primary psychiatrist, LCdr Greg Passey. In many cases, PTSD patients are forced to change caregivers when they are released; when military resources are insufficient to handle the load, many are referred to civilian mental health workers in the local area. Understandably, caregivers in civilian practice are unfamiliar with military culture and terminology, leading to frustration on the part of patients. As one soldier told us " ... I spent 30 percent of my time with the [civilian psychologist] trying to explain the military to him. He just didn't understand." That is not to say that all caregivers must have an intimate knowledge of all things military; for example, in Halifax the full-time civilian psychiatrist at the OTSSC has quickly become familiar with CF culture and, according to her patients, is an outstanding practitioner. Providing civilian caregivers with contextual material on the military and background information on specific operations can reduce much of this lack of awareness.

Location of premises

945 The OTSSCs visited by Ombudsman's investigators are physically located on base. Considering that many CF members with PTSD are reluctant to have their condition widely known, the location of OTSSCs on bases is a significant concern to a large number of patients, potential patients and some caregivers. Patients expressed fears that they will be recognized and the information passed back to their units. Investigators were repeatedly advised that many members, particularly members who are still with their units and whose colleagues are unaware of their condition, are reluctant to seek treatment for no other reason than that the OTSSCs are in such visible locations. One soldier recounted his reluctance to be seen seeking help on the base, where others would recognize him and know he had a problem:

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> I find the same thing with the social working (sic) on the base. When you go to see the social worker there, of course, it's all confidential, but you see the two guys that work in the platoon beside you. They are covering up their faces, but you know who they are. Nobody wants to let other people know that they are weak in the military. It's just the way it

> goes. It goes the same way the other way. You don't want them to know.

947 Furthermore, members with PTSD are sometimes very uncomfortable in the military environment. The mere act of having to enter a base may be stressful. Ombudsman's investigators heard of members missing appointments at the OTSSC because they were so unnerved around people in military uniform. Several members told investigators it was hard for them to be around the base because of their resentment toward the military for the way they perceived they had been treated.

948 As for caregivers' opinions, one opposed the decision to put OTSSCs on bases:

> 949 ... it would be far better to have the OTSSC downtown. We fought not to have the clinic on the Base. It is bad for patients who do not want anything to do with the military. Having the OTSSC off base will mean that patients don't have to sneak in the back door.

Care for caregivers

950 In his statement to Ombudsman's investigators, Cpl McEachern noted the demands made on caregivers:

> 951 There are too many people coming forward. The system is being overwhelmed. The people they have in the system right now are being overwhelmed with the people that are coming forward. They are trying their best. Even they are probably burning out with the workload they are getting.

952 There is serious concern among both caregivers and PTSD patients that OTSSCs and other caregivers responsible for the delivery of care to CF members with PTSD are going to burn out as a result of increasing demands for their services as more and more CF members seek treatment for PTSD. Ombudsman's investigators also met several professionals who had burned out to some degree. They heard from several quarters that, in addition to problems attracting and retaining psychiatrists, the CF has insufficient numbers of qualified clinical social workers, psychologists and other mental health professionals available to deal with PTSD and issues related to PTSD. Although padres are an important part of

the team for many members, apparently there are insufficient numbers of padres as well. According to information from caregivers in the field, qualified practitioners in these specialties are not in short supply. Additional resources are required to attract and retain suitably qualified professionals in these fields.

953 Furthermore, OTSSC staff play, or should play, a significant role in the general education of CF members concerning PTSD, particularly through outreach training. As discussed in Part Four of this report, their outreach role should be greatly expanded, for which the OTSSCs will require further resources.

954 Ombudsman's investigators encountered instances of CF caregivers overtasked to such a degree it is affecting their own mental health; a number of them were contemplating quitting or removing themselves from front-line care. Increasing workloads without increased resources, coupled with CIS management duties in response to incidents, has caused some caregivers to burn out. According to a senior military caregiver, CF health care providers are being asked to do more and more, often with already full caseloads. One senior social worker told us that the rate of burnout was "exceptionally high in trauma work, it's high [in the CF] and getting higher." She alluded to the pressures of dealing with up to two dozen traumatized clients in a week, which inevitably takes a toll on the caregiver. In addition to demanding hours of work, the intensity of trauma counselling, suicide prevention and crisis intervention, as well as the intensity of the content (e.g., atrocities witnessed by clients), can overwhelm caregivers. Sadly, that caregiver, who has a reputation as a compassionate and dedicated individual with both clients and many in the chain of command, is seriously considering terminating her relationship with the CF.

955 Based on her experience in the field, Col Marsha Quinn, the Reserve advisor to the DGHS, pointed out that the very qualities that make good caregivers may also increase their susceptibility to stress inherent in their work:

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> My greater fear is for people like the chaplains, the empaths, the people who take everything onto themselves. Sometimes the nurses fall into that category and I can say that as a nurse. You are so full of empathy — it's not sympathy; it's empathy — that you take everybody's weight onto your own shoulders and then wonder why you are having this huge problem. Yes, I think there is a sector of caregivers — and I would say that chaplains are caregivers. They care for the spiritual health of people, which is intrinsically tied to mental health,

> in my view, and sometimes the physical. I believe that those people do have a greater susceptibility to things and that is a problem in itself because they feel they shouldn't. They feel they should have developed their own coping mechanisms.

957 An LFWA member being treated for PTSD, who has a background in medicine, noted that the sole psychiatrist at the OTSSC has a huge workload. He stated, "That woman is unreal. Get her help. I have never seen someone work so hard for the troops. No one can go on like that."

958 Clearly, these demands had an impact on treatment standards. As one social worker noted:

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> Another area that is a problem for CF social workers is to adequately respond to the growing demand for PTSD-related work is current workload levels. All CF social workers are extremely overwhelmed already with a wide variety of demands. At present, most offices are dealing with such a wide scope of work demands that it is virtually guaranteed that staff struggle to keep up with adequate case management in clinical work. This obviously has implications for quality of care, no matter how good or dedicated the social worker is. "If we are too busy, we just can't keep up." It is being recognized now that within the social work organization some prioritization of work needs to be done.

960 The comments of one experienced CF social worker to investigators were so typical of many they heard from CF caregivers, they are worth quoting at length:

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> [Caregiver burnout] is an issue I feel very strongly about. I believe anyone who works too long and hard with too little recognition and reward (and I don't necessarily mean financial) is vulnerable to burnout. We need to replenish what we exert in order to stay whole as humans. However, vicarious trauma, aka compassion fatigue aka secondary trauma is what caregivers working with traumatized clients are most vulnerable to, and that's people like me and my SWO colleagues. No one else in the CF provides the level and amount of frontline support for trauma that we do. We are expected simultaneously to be in the trenches (so to speak) in order to respond to crisis and also to provide all other levels of interventions

(preventative/educative, policy writing, reactive). We are expected to be the experts at the Base, Wing and Formation level. We are mandated to educate Pers[onnel] on Stress, Critical Incident Stress and PTSD (in addition to other issues). We are also mandated to train Pers to be CIS Peers at the home unit and for when they deploy in the event tragedy occurs. Now, one of the problems we encounter depending on which command we're working in, is the belief (or lack of) in the benefit of this training.

962 We do all of this work in virtual isolation which is why most of my colleagues and I are looking forward to the proposed future provision of mental health care which involves a clinic, a multidisciplinary approach to mental health care. I believe it would also be very helpful to have regular supervision, just as my colleagues in a [CFB Base] recently trialed. We need someone to talk to about professional issues, to help us keep current, to help us wrestle through the multiple ethical dilemmas we seem to face — because we are so frequently caught between the demands of the CF and the needs of the individual — but more importantly to help us keep healthy. Right now, most of us military folks have no one we can really talk to about how hard our work is. It takes an extraordinary person to remain untainted by the stories we hear on an almost daily basis. While I was in [a CFB Base] suicide intervention sessions were routine, I was primarily, essentially a crisis worker, every day. That's gruelling work for anyone, and yet we are never adequately assessed on our courage — and I defy anyone to say that talking about suicide and murder and the innumerable atrocities our soldiers have witnessed does not demand courage. There were many days I was sitting all day long, listening to nightmare after nightmare and would come home exhausted. Times when I started to have nightmares (thankfully those have stopped). The exhaustion still happens from time to time here in [CFB Base]. I was sick when I left [a CFB Base] and am only now, after a year, feeling more like myself. My healing has also been very hard on my spouse, who wants a partner back who used to have a sense of humour and used to be more patient.

963 Most SWOs feel and are isolated. Hearing about recruiting incentives and benefits for MOs and pilots always feels like a slap in the face to me. Where are our incentives? It all makes me feel rather

> unimportant and exploited, and makes it that much harder to come to work, when the message we keep hearing is that we are unimportant. Yet I know very well, because of the work my colleagues and I quietly do, it is extremely important, and valued by our clients who often have no where else to turn, until you folks came along, thank goodness. I don't think it's an exaggeration to suggest that without SWOs the CF would fall apart (of course, I am somewhat biased).

964 Sometimes my relationship with clients seems to more closely resemble that of a torturer-confessor. It's not good to feel like the bad person when things go wrong. People seem to be quick to target SWOs when times are tough, yet we rarely hear when we've done well, and boy does it ever feel good when we do hear. Everyone should be told on a regular basis something positive about what they are doing.

965 We are isolated. I don't know about my other colleagues, but I rarely go to the mess or to socialize or let my hair down, because people seem uncomfortable to see me there. I am the secret keeper for the [unit] — at least that's how I feel sometimes. When people leave my office they have left some of their cares there (absorbed by my carpet no less!), and it makes sense that they do not wish to be continually reminded of what they are dealing with, which is what happens when they see me. I play sports and tend to socialize outside the military. But even on my sports team, I feel a wall there. There are few places where I feel I can truly let my guard down — which begins to sound like PTSD and hyperarousal (and isolation) doesn't it? So I end up holding in a great deal of my own stress inside, it is incumbent upon me to be even more creative with my coping strategies. And in order to do this job ethically, professionally, effectively, I need to be well.

966 I guess I am saying there are many reasons why it is difficult to stay healthy and which explains why some of my colleagues are either on sick leave, have quietly released from the CF or have OT'd to a less emotionally draining job.

967 LCol Matheson, the senior CF social worker, when asked by Ombudsman's investigators to comment on burnout among social workers, acknowledged that it was a serious issue:

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> The caseloads of all mental health service providers have increased dramatically over the last several years. For the social workers, who are often a first point of contact, this has been particularly evident. Not only are the numbers increasing but also the complexity of the cases. With the increasing demands for service we are seeing an increase in the number of social workers who are experiencing difficulty, i.e., increased numbers on sick leave, stress leave, etc. Although recruiting is ongoing the social work classification is approx. 1/3 below the preferred manning level. Many of the military positions are currently being filled by civilians and while their contributions are considerable many of the tasks associated with providing the service falls on the shoulders of the military member. Staffing level is one factor in terms of burnout; others include the lack of opportunity for professional supervision, education, feelings of isolation, etc. Many of these issues are being addressed in the Rx 2000 Mental Health Reform however it will be some time before they are resolved.

969 The danger of burnout is particularly acute among those tasked to do critical incident interventions. Ombudsman's investigators were apprised of one instance in which a social worker was required to provide critical incident counselling for multiple, consecutive disasters involving large numbers of deaths. It is incumbent on the CF to ensure that sufficient resources are available to ensure that caregivers have manageable workloads and sufficient downtime to recharge their batteries. Anecdotally, Ombudsman's investigators were told that the caregiving professions are sometimes the least sympathetic toward their own members who succumb to pressures. According to one social worker, the CF caregiving community "can eat our young."

970 Frustrations with the CF bureaucracy adds to the stress of increased workloads and demanding work. As one senior physician remarked, "the most stressful part of my job is dealing with the military, not the patients." On several occasions, members of the CF, some in supervisory positions, informed Ombudsman's investigators they did not always believe diagnoses by mental health professionals, while they did not doubt the ability of the medical professionals to identify physical problems.

971 In summary, escalating workloads, combined with the inherent stress of the work, frustrations with bureaucracy and perceptions they aren't appreciated are contributing to burnout and decreasing morale among many caregivers responsible for treating members with PTSD. There is clearly an urgent need to deal with the issue of care for caregivers. Workloads are unlikely to decrease in the short term. Burnout among caregivers is a very serious issue in all CF caregiving environments, not just in social work or the OTSSCs.

972 One very experienced CF social worker suggested several remedies, including: more resources; lower caseloads; use of outside consultants to examine the caregiving system and suggest improvements; and more available and responsive supervision.

Treatment and support for families

973 One senior officer Ombudsman's investigators interviewed stated that "PTSD is a family issue." A senior caregiver told them that, in many cases, the first time a member seeks treatment is "when the spouse and kids walk out of the door." Members recovering from PTSD need considerable support from family members. Members who need to travel far from the base to receive treatment should be allowed to bring their spouse and children if desired. While VAC has adopted an approach to treatment that involves (and funds) spousal travel, DND has not provided such assistance in every case.

974 Although the issue of support for family members was not raised directly by Cpl McEachern, during the course of this investigation the need for families to get support in coping with members' illnesses was glaringly obvious. Notwithstanding the fact that the MFRCs are doing the best they can to provide families with information about PTSD, more needs to be done. There can be no doubt that families of members suffering from psychological injuries suffer tremendously. According to LGen (ret) Roméo Dallaire, simply the fear of how members may be changed on returning from a deployment creates very high levels of stress for families.

975 Ombudsman's investigators encountered many families that had been badly damaged by their experiences with a family member suffering from PTSD. Anecdotally, the first symptoms of PTSD appear to be most often manifested in the home environment. Often, spouses and children are the first witnesses to the sleep disorders, the dietary problems, the memory lapses and so on; they are also often the first victims if a member develops anger management or substance abuse problems. In a distressingly high number of cases, the family unit does not survive the stress associated with living with a family member with PTSD. When it does, spouses and/or children are often in dire need of support and treatment themselves as a result of the stress they are put through coping with the member's illness. Although there may be no legal obligation, DND has a moral obligation to provide support to families coping with a member's PTSD.

976 The MFRC in Winnipeg has done a magnificent job of developing educational material for families. In addition, the MFRC organization runs a PTSD Web site including information about PTSD designed specifically as families-in-reunion briefing material. However, it is unclear whether families on all bases have the same quality or quantity of material available to them. Ombudsman's investigators heard anecdotally that educational material is not consistently available, nor does there appear to be any information specifically tailored for teenagers. Funding of MFRCs is limited and they are not easily accessible to everyone — particularly families of Reserve members. In short, the resources available within the CF to help families deal with PTSD appear to be insufficient for that purpose.

977 Ombudsman's investigators interviewed a retired Major who contacted this Office wishing to share a "success story" about his treatment by the military after coming forward to seek help for PTSD. This individual had high praise for the speedy and compassionate treatment he received from both VAC and the CF. He was particularly grateful that DND not only sent him on a five-day seminar designed to help those with PTSD cope with their illness, but that they also sent his wife and daughter on a seminar that helped them to understand his illness and helped them deal with the stress they had suffered in coping with his illness. This individual stated that his family benefited greatly from this seminar, and that it was especially beneficial for his daughter to recognize that her father's anger management problems and other symptoms were, in his words, "not for lack of love." That kind of support for members with PTSD and their families should be the standard of treatment in the CF. However, evidence heard during this investigation indicates that level of support was not forthcoming in many cases.

Peer support concept

978 Members recovering from PTSD often stated that it is important for them to be able to seek help and support from someone "who understands where they are coming from," "someone who has been there." Often, this means someone in uniform who has been on peacekeeping deployments.

979 Cpl McEachern also stated it might be helpful to those suffering from PTSD to talk to other veterans with similar experiences. Immediately after the incident on 15 March, Cpl McEachern was contacted by Maj Stephane Grenier, who is Special Advisor to the CLS on PTSD and has himself been diagnosed with PTSD.

980 Maj Grenier's intervention was clearly very valuable. Cpl McEachern stated to investigators that it was beneficial for him to talk to Maj Grenier, both in person and in regular telephone conversations. He indicated that Maj Grenier had a level of empathy and understanding that anyone who had not been diagnosed with the disorder could not have. Cpl McEachern stated that the meetings and calls from Maj Grenier "really helped me out ... calling me every couple of days, 'how are you doing buddy?', genuinely caring as a person about how you're doing and his wife has been very supportive to my girlfriend and my mother."

981 While the chain of command is to be commended for its sensitivity and leadership in permitting Maj Grenier to meet with Cpl McEachern, the question that obviously arises is: would or could the chain of command react in the same manner in less high-profile cases? Clearly, it is impractical to send members across Canada to help other members in crisis every time an incident occurs. At the same time, it is important that all CF members and former members with PTSD have a confidential and supportive place to turn when they need to speak to fellow sufferers.

982 A recent initiative within the CF has built on this concept. Maj Grenier, working within the DCSA, recently launched the OSISS project. The aim of the project is to increase the level of social support, both inside and outside of the workplace, to CF troops affected by operational stress. In the short term, the project will develop a post-treatment support network. The network will provide opportunities for serving and former CF members affected by trauma and operational stress to discuss issues of common concern with other CF members with similar experiences. A very successful initial planning session for this project was held in Petawawa on 23 August 2001. I understand that both the CLS and Armed Forces Council (AFC) have indicated their support for OSSIS, though the details of how exactly it would function are still being examined. Ongoing support for this initiative is extremely important, as is an appropriate level of resourcing to ensure it can succeed.

Confidentiality of medical information

983 Confidentiality of medical information was a serious concern for virtually every soldier interviewed, as well as of many individuals in the medical profession and the chain of command. The majority of soldiers with PTSD interviewed during this investigation did not want their units to know about their medical condition. In fact, concern that their condition not become common knowledge often prevented those with PTSD from seeking help. Because the fear of public exposure is such a dominant concern for soldiers with PTSD, and because it has a direct effect on the decision to seek early help for symptoms of PTSD, I believe confidentiality is a systemic issue that merits serious attention.

984 Current CF policy, as articulated in the 2001 iteration of *CDS Guidance to Commanding Officers* in Chapter 19, is that COs are not entitled to medical information about members under their command.

985 Cpl McEachern indicated that, in his view, a delicate balance must be observed with respect to confidentiality: while he believed his immediate chain of command should have been made aware of his condition, he was concerned that information not leak out to members of his unit who had no need to know.

986 LCol S. Bryan, who was Cpl McEachern's CO in 1997, described the dilemma that commanders in the field face with respect to medical confidentiality:

> **987** It is that balance between what I as a CO needed to know to be able to execute my responsibilities to the chain of command and to the CF and also my responsibilities to that individual and balancing them off against medical confidentiality.
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> **988** I don't need to know his condition. I don't need to know how he got his condition. I just need to know what I can do and what, more importantly, can I not do that would be detrimental to, in this case, Cpl McEachern.

989 The delicate balance or tension between the individual's need for confidentiality and superiors' need to know about those under their supervision is enhanced in the military context, where the responsibility of COs for the welfare of subordinates far exceeds the obligation in the civilian workplace. Many decisions a military superior makes concerning training, employment, career courses and so on, can potentially have a huge impact on the welfare of subordinates. Without access to specific medical knowledge, COs can make decisions that jeopardize a soldier's well-being; equally, if the chain of command is made aware of the need for accommodation, it can be of assistance in the recovery process. For instance, support from the unit has been a key factor in the success of soldiers who have recovered from PTSD.

990 A senior NCM in Cpl McEachern's immediate chain of command complained that recent protections for medical confidentiality mean that he cannot access medical information about unit members that he believes he needs to be an effective leader. As he told Ombudsman's investigators:

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> What we are finding as NCMs, particularly the Sergeant Majors who try to follow the principle of knowing about the welfare of your men, that it is kind of hard when you cannot talk to the doctor and he cannot give you any information about what is wrong with the guy, unless the individual decides to let you know that this is the situation ... There was a time when you could go and talk to the senior Sergeant within the MAs [Medical Assistants] or the doctor and get the scoop on someone, within a wider arc than there is now, so you had a better understanding of what the soldier is going through. Now you can't do that. They won't give you anything about the guy. It's the guy who has to give you that information.

992 Many soldiers interviewed by Ombudsman's investigators expressed concerns that they would not be allowed to continue to carry out their duties if their units found out they had PTSD, whether or not their medical problems were a relevant factor.

993 Some military medical providers do not trust the chain of command to correctly use or interpret information about a member's medical condition; for that reason, the only information they pass on to the unit are the limitations on employability. Other medical providers seem to have no qualms about sharing information about a soldier's psychological health with his supervisor.

994 Soldiers with PTSD to whom Ombudsman's investigators spoke were particularly suspicious of the degree of confidentiality accorded their medical information, believing it is routinely given to their unit supervisors, and used to discriminate against them.

One infanteer described the unit MO as "a puppet for the RSM and CO": he suggested that his peers seek medical help outside the battalion. Another soldier said he sought help for his PTSD symptoms from a non-military medical provider for fear that his diagnosis and treatment would become common knowledge. As he pointed out, "the PMQ [Private Married Quarters] is a very close community; everyone knows your business."

995 It is evident that many soldiers do not trust the system to protect their right to confidentiality. In one case, a serving CF member reported overhearing a senior non-commissioned medical professional discussing detailed confidential information about him with another military member in a bar downtown. When he formally complained about the breach of confidentiality, no action was taken as far as he knew. According to several members who were interviewed at this location, no one used the unit or base medical services to deal with their personal problems, as it was assumed private information disclosed in confidence would become common knowledge almost immediately.

996 In some instances the investigative team was told about, soldiers' fears of breaches of confidentiality appeared to be justified. In one such instance, a neighbour told a wife that her husband had been diagnosed with PTSD (it is unclear if the wife was already aware of her husband's condition). One Corporal who was interviewed reported he had called a 1-800 DND help-line number at NDHQ in Ottawa to obtain information about the SPHL and had spoken to a member of the military at the other end. In his words, this is what happened next:

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> I told him my story. He was pretty much shocked ... about what had happened and told me that it was 100 percent confidential and nobody was going to find out who I am and they were going to do some discreet inquiries. Two days later I was called into the OC's office. The first words out of the OC's mouth were "so you called ... and complained, eh?" Needless to say, I felt two feet tall.

998 Another soldier interviewed by investigators described the consequences of his colleagues finding out he had been diagnosed with PTSD:

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> I don't know how the hell my unit found out [I had been diagnosed with PTSD] because I never friggin [told them]. As far as I am concerned, it was a breach of medical confidentiality that someone has done. The time I went back to the unit everyone was looking at

> me sideways, and tiptoeing round me just sort of whispering, "there he goes, there goes the crazy boy ... " I don't need to be treated like a leper by a group of individuals I swore my allegiance to.

1000 A civilian psychologist with extensive experience working with military clients was asked to compare the way her military clients feel about confidentiality of medical information to the way her civilian patients view this issue. She responded:

> **1001** ... one of the primary ... differences between the RCMP and police and the military ... is the issue of confidentiality ... in almost every case of military people who come through my door, they all worry about confidentiality. They have cited examples where information has been leaked on their medical file ... Somebody came in yesterday and said that they knew for sure that this person saw their medical file because he asked him questions. He said it could only have been in my report ... I never have that concern with the police and RCMP. They never have to worry about confidentiality.

1002 In her opinion, military clients' concerns about confidentiality arise from the stigma associated with PTSD in the CF:

> **1003** They worry about the chain of command; they worry about their colleagues too, their co-workers. However, first of all, their primary concern is the chain of command because PTSD is considered a weakness. It is not acceptable.

1004 Confidentiality is a major issue in the CF and opinions on the subject vary widely. Perhaps one of the most trenchant responses on the side of strict confidentiality of medical records came from a retired psychiatrist with significant experience in treating soldiers with PTSD:

> **1005** I think [considering] the level of ignorance [about PTSD] that is at the battalion level, the less information they have, the better. I think it was a big step forward when they actually changed the regulation so that the only thing that we were obliged on the medical side to do now is list the restrictions on employability ... Because it used to be that a CO could actually find out the medical information and what I typically found with that, although it didn't happen all the time, is it filtered down and the next thing you

> know the co-workers at the section level knew what the hell was going on with this guy ... What you need to know is how are they a liability and how employable are they, so I think that was ... a big plus ... And then it's up to the individual ... the problem with that though, is the units often bully the individual into revealing the medical information.

1006 Certainly, during an interview with one unit MO, it was clear that he was less concerned about confidentiality than about keeping individual supervisors informed. In his words,

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> We may contact the supervisor. If they are performing an important role in a certain job function, we may call his or her immediate supervisor and state, "This gentleman or lady is going through a tough time and we advise this or that. We want to make sure that you are aware." If it warrants for the Sergeant Major or CO to know, they usually send it up the chain ... For most of them I just notify the medical row first, the social workers and myself, sometimes the immediate supervisor.

1008 The unit MO is often the first line of contact with soldiers suffering from stress-related injuries. Under usual circumstances, unit MOs are junior-ranking, relatively inexperienced officers. Therefore, while their level of medical expertise is high, their understanding of the workings of the military chain of command is not. In the words of one experienced CO commenting on this issue,

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> Within the unit, the unit MO is normally the most junior Medical Officer. What we find happens quite often is that after [they] graduate from medical school, [go] through basic Medical Officer training, they come here and then there is such a shortage that once they have shown some potential promise, bang, they are moved on to somewhere else. What we found a lot of times is that unit Medical Officers only stay within the unit for one year, but then they move on to a position of greater responsibility elsewhere.

1010 The lack of military experience among unit MOs helps create systemic vulnerabilities to breaches of confidentiality, or their opposite — total lack of communication with COs.

1011 COs are often in a difficult position with respect to confidentiality of medical information. On one hand, they desire the maximum amount of information to manage their troops; on the other hand, they must recognize the necessary restrictions. In the words of one CO,

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> I find nowadays as a Commanding Officer that in the medical system there are a number of restrictions on what Commanding Officers have access to. Simply saying, "You can't deploy this guy to the field for six months," why can't I? Where is the continuity to manage one's soldiers? You hold the chain of command responsible for the good order and discipline of the unit, but there has to be a certain amount of information that goes along with it. I feel that sometimes it is getting more and more difficult with your own unit MOs and things like that. They understand the work environment where they understand about the responsibility of commanders, that what you are doing is you are looking out for everyone's best interests, the unit's and also the individual soldier's.

1013 Cpl McEachern's former Company Commander pointed out that there might be some middle ground. He stated that, while he needs sufficient information to assess how to best deal with an injured soldier, it is not necessary for him to have all the details:

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> I think what is frustrating though, is that if a soldier is suffering from PTSD, it is imperative as a Company Commander that we have the relationship with the Medical Officer within the battalion. I cannot necessarily be told by him what a person's condition is and understandably I shouldn't be. That is the patient–doctor privilege and the doctor shares that privilege with the Commanding Officer.

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> However, I need to know what the man or woman's limitations are. With that kind of problem, I understand it takes a long time to diagnose, and that the treatment is long and involved, and it has to be something that is sustained. I need to know so that I can employ that person and understand the limitations to his employment.

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> If I have that relationship [of trust with the Medical Officer], then that works.

1017 In an interview for this investigation, the New Zealand military attaché discussed the approach being used in that country's forces,

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> I am not sure that we have completely resolved this sort of small problem between the psychologist and the command chain. We remind them that it is the Commander who writes your annual performance assessment ... One of the ways we have tried to make that easier for them is to be up front with the person who is needing the help to start with by saying: We are happy to help as best we can. Would you be happy to sign a waiver with respect to the discussions you have in private with the psychologist so that he or she can discuss with the command chain? If the individual says no, then that is hard.

1019 Members of the military and workers from VAC have both expressed concern to Ombudsman's investigators about modifications to the rules about confidentiality concerning information VAC is required to provide DND about soldiers seeking support. Under rules that have recently been introduced, before a claim with VAC can be initiated, a soldier must sign a waiver of confidentiality to allow VAC to share information with DND medical authorities. This change is deemed necessary to implement a joint DND/VAC arrangement in caring for soldiers. There are strong and legitimate reasons within the DND medical community why this information is necessary. According a senior MO,

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> ... the answer is we are going to share data. It is going to start soon ... There is a health and safety issue. If we have members that go to VAC for treatment and don't divulge to us, they could be on all kinds of medications that we don't know about, leading troops, running machinery, driving vehicles, that could ultimately injure themselves or someone else. As a health care professional, I just can't accept that for their safety or anybody else's. I understand their concerns, but to me there is a bigger moral issue than that.

1021 While the joint DND/VAC arrangement will provide a highly desirable end result — seamless transition from active service to civilian status — it is a matter of great concern for soldiers with PTSD who fear disclosure of their condition. Safeguarding the confidentiality of a member's medical information will be even more important under the new rules.

1022 The chain of command has been directed not to ask members about their medical limitations directly, as per CANFORGEN 076/98:

1023 Medical Officers will henceforth be the approving authority for medical limitations to employment. Should the chain of command have any concerns with individual cases where employment limitations have been ordered, they are to raise their concerns with appropriate medical authorities and not with the individual serving member.

1024 In summary, although there appears to be no easy solution to this problem, it is one that requires further study. Meanwhile, breaches of confidentiality of medical information are clearly unacceptable.

Resource issues

1025 Pressures on CF personnel are mounting to such an extent that, not only do they limit the ability of the organization to care for CF members with PTSD, but they are also an underlying cause of increased stress-related illness in the organization as a whole. The issue of insufficient personnel to accomplish the work in the CF is so central to how the CF deals with PTSD, it cannot be ignored in a report of this kind. Two areas in which insufficient personnel affect the way the CF deals with PTSD are: first, increased levels of stress caused by insufficient personnel in the CF in general; and second, the lack of sufficient mental health personnel and stable funding needed for OTSSCs to address increased levels of stress and stress-related illness such as PTSD in the CF.

1026 In the CF in general, the military has been working under personnel constraints for the last number of years. Every unit the investigative team visited reported that it's working below the authorized number of personnel, creating heavy workloads. Increased operational tempo is another concern, noted by both SCONDVA and the Croatia BOI. Investigators heard from all levels that the pace of operations, including training and instructor duties, has increased considerably over recent years. The combination of high workloads, particularly for senior NCMs, and shortages of personnel at the unit level, in addition to operational tempo, is often quoted as an underlying cause of stress-related illnesses in the CF.

1027 This report has already discussed in Part Three the effect of pressures on CF personnel on attitudes toward CF members with PTSD — resentment when any member of the unit is unable to deliver 100 percent, even for a short time, because others must pick up the slack to maintain output.

1028 As a result of the pace of operations and increased demands on all CF members, virtually every position within the CF is now considered essential for operations. Traditionally, a number of positions in units could be filled by members not fully capable of performing their duties. Under current conditions, however, there is simply little or no flexibility left at the unit level to absorb such personnel.

1029 Over-tasking is perceived as being at least partially responsible for the high level of stress in today's military. Ombudsman's investigators frequently heard that "there is just no break anymore." When asked if he thought over-tasking, including duties related to deployments, was contributing to the stress problems, one CO responded:

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> Absolutely. One of the contributors is certainly going overseas about every two years. This battalion went over in 1993. It went over in 1997. It was geared up to go in 1995 also, but it got stood down and they sent a brigade headquarters. That was the transition from UNPROFOR over to NATO-led, UN- to NATO-led. So 1993, 1997 and we went in 2000.

1031 Many CF members at all levels and family members identified constant taskings between deployments as a major factor contributing to high stress and low morale in the CF. Ombudsman's investigators interviewed an experienced infantry officer, who stated that:

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> Where do people get the breaks? We keep on talking about morale in the Forces. What do we do? We throw money at it. Sure, I will take your money, but how about a break? When is the break for everyone? If you look at the units in Edmonton ... they have done all their training and they know they have a Roto coming up on the horizon. What are they doing this summer? Summer tasks. The time you should be spending with your family and having a little slack time, they are all doing summer tasks, whether it's training the militia, training the Regulars or training cadets. That is the problem. The taskings are killing us. Honest to God, I swear the taskings are killing the Army as a whole. If you are not in the unit and busy, you are outside the unit and busy ... It is just go, go, go, task, task, task. Where are the breaks for our people? I don't see it.

1033 A senior NCM, currently deployed overseas, expressed the same sentiment about the number of deployments:

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> There are not enough soldiers to sustain our commitments. There are too many tours too many times. There are too many people on sick leave or undeployable, leaving the same people deployed all the time. There are no replacements when people are removed from the workplace.

1035 According to a psychologist who treats a large number of CF members, there is a direct connection between the increased frequency of PTSD and high levels of stress even before individuals are deployed:

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> The short version is that people are stressed before they are even deployed. They are often going on exercises. They are preparing to get ready for deployment. The families are stressed because dad is going to be gone or mom is going to be gone for a long period of time, and there isn't a lot of support there predeployment.

1037 The pace of operations and the shortage of personnel also affects the chain of command's ability to devote the amount of time necessary to properly care for troops, in the opinion of many soldiers. In the words of one young Major with experience in peacekeeping operations:

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> The officer corps, the seniors, the senior NCMs are so consumed by the tempo right now and by all of these tasks and activities that they have a battle on all fronts. We have taken the time away from them to do those little things that are required and that, for the most part, you would do normally outside normal hours ... Walking in at six o'clock in the morning, talking to my troops, or staying after hours, six o'clock or seven o'clock, or going back at night, these are the kinds of things that you would see, but now with the tempo, it puts the question to me: Do the folks still have the time to dedicate to their people? ... I don't think there is malice on the part of the officer corps. The folks are still there trying to do their best, but right now the best is not good enough. If you are 50,000 people going down to, I don't know, 49,000, and you still have on the plate enough work for 60,000, something has to give. Unless you find the spare capacity ... unless

> you force the system to identify the spare capacity and you have some direction to move that spare capacity to fix it, the problems will just keep compounding and will get worse. What I have witnessed for the last 18 months is exactly that.

1039 To its credit, the CF has acknowledged that operational tempo is a serious issue that requires tackling. CANFORGEN 035/01, issued on 30 March 2001, noted that "the large amount of time many CF members spend away from home creates a number of serious challenges." It advised that the Human Dimensions of Deployment Study being conducted by the Quality of Life Project, begun in the fall of 1999, will comprehensively deal with operational tempo issues.

1040 As noted previously, the shortage of military personnel is an important factor in the resentment and bias that exists against those who are recovering from PTSD. Preparations leading up to tours is an added burden that increases the stress and time spent away from "normal family life."

1041 Indeed, during the course of this investigation, spouses of CF members identified the effect of increased operational tempo on families as a major stressor. In a family deployment briefing held in Winnipeg prior to Roto 7, the one question repeated at each session was "is it true you are going to be sending the troops away on exercise when they get back next March?" According to a senior MFRC worker, members' spouses have already pointed out the fact that, the next time the unit is due to be deployed (in Roto 12), 2 PPCLI is simultaneously scheduled to move to Shilo. Understandably, the timing of the move is already causing great concern among families even though the anticipated stress is relatively far away in time.

1042 The shortage of personnel and extreme workload is not limited to field units, but is also felt within higher headquarters. This, too, reflects on the manner in which the PTSD issue is dealt with. A staff officer in the ADM (HR-Mil) organization at headquarters commented on this aspect:

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> The difficulties, if there are any, are all tied to resources at the OPI level. They are either overworked or over-programmed. It is relatively moot. I am fairly convinced that the top of the pyramid is much more aware of the situation, PTSD being just one of a myriad of situations, but I don't think that awareness gives you depth, and that is probably the fault of two things. First of all,

> seniors — General Couture [ADM (HR-Mil)] has an incredible span of control. He is to be responsible for so many things, so getting me in to see him, getting his attention — it is not that he is not accessible, it is just that there are so many things. The other thing, of course, is that if ... people are not coming forward, then there is no sense of the magnitude of the problem. That may well affect the amount of resources that are being devoted to the system.

1044 The second area in which insufficient resources directly affects the way the CF deals with PTSD concerns the infrastructure for treating PTSD — particularly with respect to the OTSSCs.

1045 As noted above, the investigative team encountered very few criticisms of treatment provided by OTSSCs. In fact, members were virtually unanimous in their praise for the quality of the care they received from the centres. Ombudsman's investigators were very impressed by the high level of dedication and commitment they observed in the staff of the centres they visited. In general members diagnosed with PTSD acknowledged that the treatment provided by the CF appears to be at least equal, if not superior, to that available to civilians.

1046 When asked about issues involving the hiring of personnel at the OTSSCs, a senior MO who was involved in the running of the OTSSCs stated:

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> ... we were asked recently by the Minister if he could throw more money at me if it could help solve problems. I told him I couldn't spend what I have now. It is not from lack of trying. We are having great difficulty finding the health care providers that we need to provide the service. Psychiatrists in particular are the most difficult to find.

1048 Her view was emphatically not shared by many caregivers to whom Ombudsman's investigators spoke. While the issue of finding qualified psychiatrists is no doubt problematic, there are many areas in which personnel, other than psychiatrists, are in demand, both in the OTSSCs, and in mental health services in the CF in general. As we have seen elsewhere in this report, additional personnel are also desperately needed to deal with caseloads carried by caregivers who are not doctors. Further, there is a clear need for OTSSC members to have sufficient resources to permit effective and comprehensive outreach and education programs, as indicated in Part Four of this report. This is particularly important to ensure that deployment-related training is as effective as possible. In my view, additional resources should be made available to the OTSSC to free up the time of qualified professionals to focus on patient care and education.

1049 That said, it is true that psychiatrists are difficult to recruit. According to the Director of Mental Health Services, Col Randy Boddam, there is a serious shortage of psychiatrists and psychologists in Canada; in fact, the average waiting time for Canadians in the civilian sector to see a psychiatrist is approximately six months. Despite the heavy workload for the OTSSCs, however, waiting time is actually somewhat shorter within the CF than for Canadian citizens in general. According to a senior CF MO, "I know it is no consolation to our members, but our waiting times are actually considerably shorter than they are on the civilian side. Despite the fact that they seem long, they are still shorter."

The financial costs of not dealing with PTSD

1050 The minimum cost of developing a basic infantry soldier to the point where he or she is considered combat-ready and experienced (Corporal-qualified) is approximately $315,000 according to a recent calculation provided by the Land Staff. In other words, the CF will have invested that amount by the time a soldier is likely to be deployed and be at an increased risk of PTSD. Given that level of investment, it is logical to make every attempt to retain an individual in the CF, even in other occupations if necessary for medical reasons.

1051 If an OTSSC succeeds in returning as few as five soldiers a year to the workplace (at the minimum investment level of $315,000), it will have achieved a 'cost avoidance' of approximately $1,575,000 for the CF — well in excess of the current cost of operating an OTSSC. Using information provided by the Halifax OTSSC, the cost to treat between 200 and 250 patients annually is approximately $1,138,000 per year. Therefore, five soldiers a year represents approximately two percent of the caseload of the Halifax OTSSC, and the cost to treat each patient is approximately $5,000 per year.

1052 Conversely, if a soldier does not receive treatment early on and the disorder progresses beyond the point that the soldier can be rehabilitated, the costs of treatment (either shared by DND and VAC or borne by VAC alone) can be considerable. One soldier who has had symptoms of PTSD for the last eight years advised the investigative team that the cost of his treatment to date approaches $250,000. Although VAC does not keep specific statistics on the costs of treatment for former members diagnosed with PTSD, total expenditures for treatment of VAC clients pensioned with psychiatric illness exceeded $1 million for the first eight months of 2001. Compared with the last eight months of 2000, costs of treatment have increased by 15 percent. The long-term cost to Canadians of not dealing with PTSD is likely to be significant.

1053 Aside from humanitarian and operational considerations, it is in the best economic interests of DND, VAC and the Canadian public to:

1054 a. identify and treat stress-related casualties as soon as possible;

1055 b. establish and fund OTSSCs to a level sufficient for them to plan for and handle the workload;

1056 c. provide sufficient medical resources to treat all stress-related injuries as soon as possible; and

1057 d. educate all members of the CF in mental health issues to the point where they can recognize symptoms of stress-related illness and seek early treatment.

Litigation

1058 As noted above, the financial costs of treating CF members with PTSD are insignificant compared with the costs of recruiting and training a replacement. There is also one other significant financial implication of failure to deal appropriately with PTSD in the CF: by not providing its members with appropriate care, the CF may be laying itself open to litigation. In the United Kingdom, the courts have awarded considerable sums to soldiers who were not suitably treated when they were diagnosed with PTSD. In one case, a soldier who served in the Falkland Islands was awarded £100,000 (C$220,000) after the High Court found that the army had failed to treat his PTSD. According to media reports, over 300 veterans are suing the UK Ministry of Defence for its alleged failure to diagnose and treat PTSD, for a potential cost of £15,000,000 (C$33,000,000).[18] A former Irish Army officer recently received

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[18] *The Guardian*, April 3, 2001.

£80,000 (C$176,000) from the Irish Department of Defence in settlement of a claim that involved PTSD.[19]

1059 In a paper sponsored by the CF about post-deployment support published in 1997, the authors found that "the concept of mental injury as a compensable entity has now been established in many parts of the world." [20] The paper quoted an incident involving the Royal Australian Navy in 1964, in which 82 Australian Defence Force (ADF) sailors lost their lives. Thirty years later, over 80 compensation claims for psychological trauma were still before the courts. In 1997, a single claimant was awarded $1.7 million Australian, reduced on appeal to $819,000. Potential payouts for this incident are estimated at between $30 million and $80 million. It is unclear what, if any, proportion of the settlement related to care provided to members by the ADF, but the report recommended that senior commanders "require an awareness of the major legal implications of traumatic stress *and its management* [emphasis added]."

Recruitment and retention

1060 The CF is experiencing a shortage of trained personnel, particularly in the occupations that are deployed. As a result, the new CDS, Gen Ray Henault, has identified recruitment and retention as a priority and assigned resources accordingly. The pressure on CF personnel is reflected by the fact that it is aiming to recruit some 9,000 new members to begin building numbers back up to the authorized personnel ceiling.

1061 The perception of how the CF cares for members with stress-related injuries increases the difficulty of both attracting recruits and retaining current members. To be successful in its recruitment and retention goals the CF must be seen to be a caring employer that does its utmost to look after those who become ill or injured while serving.

1062 Ombudsman's investigators heard significant anecdotal evidence from several sources that this is not the perception of many within the CF. As an experienced, well-educated and well-trained young Major told Ombudsman's investigators, he was planning to leave the CF for reasons directly related to the way he perceived the system failed to take care of Cpl McEachern and others injured in the line of duty:

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[19] *The Sunday Times*, November 8, 1998.

[20] *Post-Deployment Support: Guidelines for Program Development*. Major P. J. Murphy and Capt. G. Gingras (focus group report), December 1997.

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> I am a case like that. I am departing after 20 years. Why am I departing? With all of the investment that has been made in me, I should have stayed ... So why should I have now a vote of confidence in staying in a system that has failed me? That answer you will get across this country from soldiers ... Unless you come up with very direct actions where people will be able to take the signals that there is change occurring, the situation will not get better. The McEachern case and all of the other cases that happened, people find out, people hear, and a system that is on the decline like that is because people are looking at the way that we take care of the people on the way out.

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> I would go back to a root cause here a couple of years ago with [a senior infantry officer who had returned from Bosnia], for those who remember it. The guy came back with a leg missing ... When he came back, why is it that it was the private sector that kicked in to get him a job and fixed some of those errors that we made as an institution? Why is that? ... What kind of signal does that send to me? Where is the confidence? It is not because of bad will or the bad intent of people. To me, people are doing their best. It is a system problem. We have lost that focus, the consolidated and co-ordinated effort to get the right things done. Until you kick this back in, the system will not get better.

1065 It appears that the CF is missing an opportunity to retain people in whom it has already invested a great deal of training and resources. Given the importance assigned to recruitment and retention, although precise statistics are not available, it appears that many soldiers with PTSD have a higher probability of recovering and returning to full-time duty if their illness is identified early and treated appropriately. Indeed, Ombudsman's investigators interviewed a number of soldiers who had been diagnosed with PTSD and who had returned to perform full-time duties. Cpl McEachern himself is an example of how the CF failed to retain a good soldier who, had he been given an Occupational Transfer when recommended by his doctor, would likely be still a productive and proud CF member.

Co-operation/co-ordination challenges

1066 A major issue concerning the effectiveness of the CF's approach to PTSD that has arisen during this investigation is the lack of internal co-ordination among various parts of the organization. Co-ordination, both within the CF and between the CF and a number of external organizations, is also necessary to ensure a smooth transition to civilian life for CF members being medically released.

OTSSCs and VAC

1067 As Cpl McEachern pointed out, members who suffer from PTSD often find it difficult to change therapists. Nonetheless, at the present time, the treatment for soldiers diagnosed with PTSD is the responsibility of DND; if, however, the disorder eventually results in their release from the CF, treatment becomes the responsibility of VAC, using therapists employed by VAC. Furthermore, programs available to veterans under the VAC mantle are not available to CF members and vice versa. As a result, the CF and VAC are jointly developing the "Continuum of Service Project" to expand the OTSSCs so as to include patients currently the responsibility of VAC, as well as to make a wider range of VAC services available to serving members. The medical advantages to this plan are inarguable: not only will members with PTSD be able to make the transition from active military service to veteran status without changing therapists, but Reservists and others will also have access to OTSSCs.

1068 CF Health Services is considering a trial involving co-operation between DND and VAC in the operation of the OTSSCs and the VAC Ste. Anne's Hospital, near Sainte-Anne-de-Bellevue, to facilitate the transition for the soldiers when they enter the system. Ombudsman's investigators were told two meetings have been held and the process is under way. The senior medical staff officer at NDHQ responsible for overseeing this program reported as follows:

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> Ultimately our goal is to mimic the Centre where we have people working there that are DND employees, uniformed or otherwise, VAC employees, but they are working in one place for one patient that is going to be on either side of that divide, in uniform or out of uniform. Hopefully, they won't notice the divide.

1070 As discussed earlier in this report, one of the disadvantages of this otherwise positive development for many CF members with PTSD is that confidential medical information provided to VAC will be shared with DND. Currently, when a CF member applies to VAC for an assessment, no information is provided to DND. Although confidential information should be shared only between medical professionals, members' distrust of the way in which confidentiality has been handled at DND raises concerns about the implications for DND interaction with VAC.

1071 Another concern about the joint DND/VAC access to the OTSSCs is that unless the resources allotted to OTSSCs are increased commensurate with the increased workload, both soldiers and veterans will have to wait longer to access care.

1072 Currently, no standard, acceptable waiting period has been set for soldiers seeking help from OTSSCs; the system tries to match the waiting period that applies for civilians in the local area. In the absence of an accepted standard, the direct relationship with resources is difficult to establish. However, the situation of military personnel is not comparable to that of civilians: in at least one situation reported to investigators, an individual was deployed while he was waiting for an assessment. Furthermore, in less populated areas, the need for military referrals to civilian facilities actually increases the average waiting period for civilians in the local area, artificially lengthening the standard waiting time.

Co-operation among VAC, DND and SISIP

1073 DND, VAC and the Service Income Security Insurance Plan (SISIP) all share responsibility for the care of military members with medical disabilities released from the CF. SISIP is effectively the CF members' personal disability insurance program, for which CF members pay premiums. Financial benefits, as well as job retraining programs from SISIP, play an important part in members' transition plans. Unfortunately for many CF members with PTSD on the SPHL, SISIP retraining benefits do not kick in until a member is within six months of release, whereas many members may need to start this retraining soon after they are placed on the SPHL as part of their therapy.

1074 One of the recommendations of the Croatia BOI was that the CF "Ensure better information sharing among the Canadian Forces, Veterans Affairs Canada and Service Income Security Insurance Plan, with the aim of reducing the gap between the end of military service and the start of benefits" (Recommendation 23). As a response to this recommendation, the CF pledged that "DND will be a pro-active force in its efforts to solidify and increase current partnerships with VAC [and] SISIP, and will regularly publicize results."

1075 Fortunately, VAC benefits are largely available to serving members, and this does ease the transition. Effective 1 March 2001, VAC created transition co-ordinator positions in Ottawa and on four bases (Esquimalt, Edmonton, Valcartier and Gagetown) to assist CF members with claims, procurement of service and medical documents.

1076 I am encouraged by progress in the area of improved co-ordination of services for members on or awaiting release and I sincerely urge all three organizations to continue efforts at co-operation.

Case manager system

1077 A case manager is a health care professional appointed to oversee an individual's care from initial diagnosis up to and including release and transition to VAC care. According to DGHS BGen Mathieu, who is responsible for implementing the case manager system, the preliminary survey data from a pilot project is encouraging:

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> We have a pilot ... right now at five sites, our four army bases and Ottawa. It has been going on just a little over six months, I guess, and we have collected our first satisfaction survey. It is generally pretty good ... if you look at our rating scale of one to ten, 75 percent of the people are rating it eight to ten ... we are going to SRB [Senior Review Board] in June to get approval for the rest of them where we will now start to tackle the temporary medical category ... we pick them up [when they are placed on a temporary category] rather than waiting until they are released. It could be two years before they are released, but we will have case managed them for two years through all their problems and the connections to various resources ... ideally our goal is to get people back to work ... but where that doesn't work, help them through the release process.

1079 The Senior Review Board (SRB) for the case manager concept held on 19 June 2001 approved the rest of the initiative and implementation is under way. The plan calls for case managers to be civilian nurses trained in psychological illnesses.

1080 In my view, the case manager system is a promising development, with the potential to establish continuity of care in the CF health system.

Co-operation among DND organizations associated with PTSD

1081 Social workers, medical personnel, chaplains, volunteers and other personnel associated with providing care to members diagnosed with PTSD or their families do not always share information on or agree on the best method of treatment for specific individuals, often because of "turf wars" that occur both on deployment and in garrison. Clear lines of responsibility are necessary for social workers, padres and medical personnel, as well as for volunteer personnel where appropriate.

1082 Padres (military chaplains) told Ombudsman's investigators in no uncertain terms that medical personnel and/or social workers do not always consider them part of the team. In an interview, a padre who was deployed reported that the lack of co-ordination between newly arrived social work and medical teams and the padre caregivers already on the ground in theatre is a major issue. She felt that the trust and confidence she had built up with the soldiers was largely ignored by the 'professionals,' to the soldiers' detriment. Several soldiers echoed her sentiment. CF padres clearly go well beyond the spiritual service provided by their civilian counterparts, and their contribution ought to be considered as part of the team effort.

1083 The lack of co-ordination among different agencies within DND and the absence of a clear OPI are also hampering implementation of many of the recommendations of the Croatia BOI and the Lowell Thomas Report. This does not necessarily reflect a lack of co-operation, but may simply be the result of a lack of awareness of what is happening in other areas of the department. In the words of one senior officer who has been trying to track implementation of these recommendations, "We are trying to tackle recommendations one by one in isolation ... each capability or each group was looking at their specific recommendations in a silo."

1084 The tendency has been to simply count the number of recommendations implemented in isolation to measure success, rather than to assess the effectiveness of combined efforts. This lack of co-ordination can have serious results. In the words of one officer:

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> By getting it back into a matrix,[21] we ended up dividing it along, everybody taking care of their own part, but not looking at the compounded effect, and it can't work. The McEachern case — there are four or five distinct activities here, each dealing individually with the case; not necessarily talking to each other and not coming up with a combined solution. Yet if you look in the field, we work in a combined environment.

1086 According to another senior staff officer of NDHQ, the solution is relatively simple: "I think the real key of the issue is to have someone take charge." He commented:

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> I think, as we all know from the [Croatia BOI], that it is not a medical problem and it is not a production problem, it is a multidisciplinary problem and it has to be addressed along those lines. If we can't get it straight for just a couple of people, we are really heading for the hopper.

PTSD co-ordinator

1088 This report has identified particular aspects that I believe are important in understanding what happened in Cpl McEachern's case and has made recommendations to improve the way in which the CF deals with PTSD. However, as noted throughout the report many of the issues examined in this report go beyond the responsibilities of a particular unit or environmental command: for example, overall responsibility for formal education about PTSD belongs to CFRETS, while deployment-related training for units largely falls under the aegis of the environmental command or, in the case of the Land Forces, each Land Force area; medical treatment comes under the purview of the DGHS, while the SPHLs come under both base and unit command, subject to directives from NDHQ. In other words, a large number of disparate authorities affect how the CF deals with PTSD.

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[21] The term 'matrix' refers to using personnel from different organizations with separate reporting chains to work together to solve a problem. While using the matrix is an efficient method of getting multidisciplinary expertise, there is no single point of contact responsible for an issue.

1089 In my view, a single, overseeing authority, mandated to take a holistic approach to PTSD and related issues, is necessary to effectively deal with this complex challenge in a military context. While most CF decision makers with whom the investigative team has met are willing to make improvements, a co-ordinated approach, CF-wide, is needed. A central co-ordinator could play a valuable role in helping to standardize and unify education and training about PTSD by acting as a resource and advisor, CF-wide. Furthermore, a PTSD co-ordinator could facilitate contact between decision makers and CF members who have been through the system as patients, giving those with PTSD an opportunity to contribute to improvements to the system. Similarly, the CF is acquiring valuable experience in dealing with issues related to PTSD, yet there is no mechanism whereby the lessons learned can be shared with the gamut of interested parties as a whole, from COs to caregivers to educators, who could greatly benefit from each others' experiences. To address this failing, I recommend the position of PTSD co-ordinator be created to co-ordinate approaches to PTSD and related issues across the CF. Whether, and to what extent, the incumbent would have any direct executive authority must be determined. However, given that PTSD is a CF-wide issue and the need to demonstrate that the CF is taking the issue of PTSD seriously, I believe that the person selected should report directly to the CDS as his special advisor on PTSD. The PTSD co-ordinator will also require a small staff.

1090 I fully recognize the importance of the chain of command, and I anticipate there may be some reluctance in some quarters to support an initiative that may be seen to circumvent normal reporting relationships. However, having an individual or group report directly to the CDS is by no means a novel, nor even unusual, step. For example, in February 1999 the CDS created a position of Special Advisor to the Chief of Defence Staff on Officer Professional Development.[22] The incumbent, currently BGen Charles Lemieux, reports directly to the CDS with a mandate to act "as his principal agent on all matters dealing with professional development in the CF." According to the terms of reference for the office, the mandate includes advisory and strategic planning duties for professional development of all ranks, as well as acting as the representative of the CDS at all ADM (HR-Mil)-sponsored professional development forums. The Special Advisor also acts as the link between the CDS and the Leadership Institute.

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[22] In January 2000 the title of the office was changed to Special Advisor to the CDS on Professional Development.

1091 Other examples of reporting relationships to the CDS outside of the normal chain of command include the Director General of Public Affairs (DGPA), who reports directly to the CDS. I was advised by the former CDS that the Joint Task Force 2 also reports directly to the CDS.

1092 I appreciate that recommending that the co-ordinator report directly to the CDS is an exceptional, though by no means unprecedented, step. However, I believe that issues related to PTSD have created such acute challenges for the CF that an exceptional solution is required.

1093 The PTSD co-ordinator would perform the following functions:

1094 - be the focal point for issues related to PTSD CF-wide;

1095 - act as a resource to the chain of command in dealing with issues related to PTSD;

1096 - act as a repository of lessons learned for issues related to PTSD;

1097 - evaluate best practices and educate others;

1098 - ensure that caregivers, educators and the chain of command are aware of issues related to PTSD and apprise them of developments;

1099 - act as a confidential source of information and referral for members who may require assistance;

1100 - identify gaps in the system and measures necessary to deal with them;

1101 - co-ordinate education and outreach initiatives for family members of those with PTSD;

1102 - champion the peer support or 'buddy' system mentioned in this report;

1103 - co-ordinate delivery of specialized education, training and information briefings to the chain of command and units;

1104 - act as a resource as incidents occur (in this capacity, the co-ordinator and staff would be available to provide general advice and referrals to COs and others in the event of major incidents, either on deployment or in Canada);

1105 - advise on administrative improvements (such as VAC liaison, the SPHL process);

1106 - assist in developing effective educational and training materials;

1107 - provide information and staff for outreach initiatives;

1108 - assist in the development of collection of accurate data from CF sources;

1109 - monitor developments in how other militaries deal with issues related to PTSD;

1110 - monitor developments in treatments of PTSD, in conjunction with DGHS; and

1111 - act as the public face of the CF for dealing with PTSD.

1112 This is by no means an exhaustive list of what a PTSD co-ordinator may be tasked to deal with. As noted throughout this report there are a multitude of issues related to PTSD that affect the CF. I anticipate that the co-ordinator's office would quickly become a centre of expertise available to all CF members, including the chain of command and those within the CF who are seeking help. I believe such an approach is essential if the CF is to tackle issues related to PTSD in the CF successfully.

Summary and recommendations

1113 It is important that the CF closely monitor the effectiveness of relatively new measures to ensure units follow up with Reservists and augmentees are in practice.

1114 I therefore recommend that:

19. The Canadian Forces audit and assess the effectiveness of policies and procedures designed to assist Reserve Force members and augmentees pre- and post-deployment.

1115 The key to a more flexible policy regarding placing CF members with PTSD on the SPHL may be to provide COs with increased resources to maintain effective unit SPHLs to look after their injured within the unit, including sufficient resources to maintain a manageable operational and training tempo.

1116 I therefore recommend that:

20. The Canadian Forces review policies and procedures with a view to making them as flexible as possible to accommodate the needs of members who have been diagnosed with PTSD and wish to remain with their units for as long as is possible.

1117 Clearly, the decision to place a CF member on the SPHL should be made based primarily on the member's best interests, as stated in CANFORGEN 100/00. Selective interpretation of this directive is unacceptable.

1118 One way to avoid situations in which Career Managers refuse or delay requests to place soldiers on the SPHL is to give the final authority for the decision to the MO rather than to the Career Manager. There should be some mechanism by which the member's CO also has an opportunity to have input into the decision. In that way, the focus remains on the best interests of the patient rather than on the requirement to fill a position.

1119 I therefore recommend that:

21. The Canadian Forces review procedures for placing members on the SPHL to ensure a greater role for input from Medical Officers and Commanding Officers.

1120 In my view, it is evident that members with PTSD should be managed as close to their units as possible. Evidence indicates there is very little chance members will recover and return to their units once responsibility for their welfare has been transferred outside of the unit. It is also of positive therapeutic value for those with PTSD to be gainfully employed within the unit whenever possible. It would set a positive example for all soldiers to see that those with stress-induced injuries are not discarded or isolated from the unit and can continue to contribute to the unit. However, for this goal to be effective, sufficient resources must be provided to give units sufficient personnel to meet all of their commitments, including the task of looking after ill or injured members as close to their unit as possible.

1121 I therefore recommend that:

22. Units maintain contact with members on the SPHL bi-weekly, subject to any restrictions imposed by the member's treating caregiver, or any desire expressed by the member.

23. The Canadian Forces address resource issues that are preventing units from properly looking after members diagnosed with PTSD within their units.

1122 The lack of co-ordination among the five existing OTSSCs is of concern to the CF medical system. I wish to encourage efforts at standardization, as I believe this will ultimately be to the benefit of patients and caregivers.

1123 I therefore recommend that:

24. The Canadian Forces prioritize and accelerate the efforts toward standardizing treatment of members diagnosed with PTSD among OTSSCs.

1124 The established level of resourcing for the OTSSCs is insufficient to meet the current demand. If greater numbers of soldiers with symptoms of PTSD come forward, the resource level will be woefully inadequate, and OTSSC caregivers will be over-burdened and burn out. Workloads for the OTSSCs will also increase as a result of joint initiatives by DND and VAC to allow those that have left the CF increased access to the OTSSCs.

1125 I therefore recommend that:

25. OTSSCs be resourced on a priority basis, and to a level sufficient to perform all of their designated functions.

1126 The objectives of the OTSSCs include providing assistance and treatment to members and their families who are dealing with operational stress and trauma. Any obstacle to members getting treatment at the earliest possible juncture must be addressed. While moving OTSSCs to more anonymous premises off-base would require considerable resources and inevitably involve some disruptions, I believe a pilot project to determine the value of moving OTSSCs to off-base locations is called for.

1127 I therefore recommend that:

26. The DGHS initiate a pilot project that locates one OTSSC off-base, to ascertain whether such an arrangement is better suited to the objectives of the OTSSC.

1128 Healthy and competent caregivers are critical to the CF's ability to handle PTSD casualties. However, as a group they are extremely vulnerable to stress: constantly exposed to members who suffer from trauma, they are sometimes engaged in fighting for resources and other supports. Furthermore, their diagnoses on specific patients are sometimes challenged by the operational chain of command in a way that adds to their stress and undermines their authority.

1129 I therefore recommend that:

27. The Canadian Forces take steps to deal with the issues of stress and burnout created by lack of resources and high caseloads among Canadian Forces caregivers.

1130 The requirements of spouses and children of members with PTSD are not always met. Consequently, the people who are often the first to see the signs of PTSD do not always have the information they need to understand the illness and react appropriately. Families can be a valuable source of assistance in identifying PTSD and in supporting treatment, but they are a source that is not always tapped.

1131 I therefore recommend that:

28. The Canadian Forces take steps to improve support programs designed for the families of members diagnosed with PTSD, at all elements and locations.

1132 Ongoing support for the peer support concept is extremely important, as is an appropriate level of funding to ensure it can succeed. I therefore recommend that:

29. The Canadian Forces continue support for the Operational Stress Injury Social Support initiative and provide resources as required to extend this or similar programs across the Canadian Forces.

1133 CF members with PTSD are very concerned that the confidentiality of their medical condition will not be respected. They do not trust the military medical providers to maintain confidentiality and they fear that if the diagnosis of PTSD is disclosed to their units, the stigmatization so prevalent in the units will jeopardize their jobs and eventually force them to take a medical release. At the same time, commanders are finding it increasingly difficult to acquire sufficient information about the people they supervise to do their jobs properly. It is difficult to hold commanders accountable for the welfare of the troops if they are denied critical information about personnel under their command. The key may be to explore avenues that will create an atmosphere of trust between the member and his or her chain of command, so that all parties have the information they require to best assist members who are sick.

1134 I therefore recommend that:

30. The Canadian Forces initiate an end-to-end review of the rules dealing with confidentiality of medical information. In the short term, breaches of confidentiality must be dealt with quickly and visibly to re-establish confidence in the Canadian Forces' commitment to protect personal information.

1135 The various organizations and professions that are responsible for helping soldiers with PTSD do not always share information or work together effectively. There is clearly a need for better communication and information sharing between medical professionals and others who provide support to patients with PTSD. One solution to this problem is to create a position within the CF responsible for co-ordinating how the CF deals with issues related to PTSD.

1136 I therefore recommend that:

31. The Canadian Forces create the position of PTSD co-ordinator, reporting directly to the CDS and responsible for co-ordinating issues related to PTSD across the Canadian Forces.

Conclusion

1137 I have found Cpl McEachern's complaint that he was stigmatized and unfairly treated by the CF as a soldier diagnosed with PTSD to be substantiated. As a result of the failure of the system to take care of one of its own, Cpl McEachern was left to suffer alone, without the support that could have sustained him as a contributing member of the CF. Consequently, the CF has lost a good soldier. Most disturbingly, however, the unfair treatment that Cpl McEachern endured is not a unique or isolated occurrence.

1138 This investigation would not have been possible without the courage of Cpl McEachern and other CF members and their families who shared their personal experiences with my investigators. They should be commended for their willingness to come forward so that others may benefit from their pain and frustration. CF personnel who had the courage to acknowledge that the system can do better should also be applauded for their honesty. I am satisfied that this report has captured the real experiences of CF members and their families suffering the effects of PTSD and that it contains many concrete solutions to real problems. This achievement would not have been possible without the advice and counsel of the Special Advisor to the Ombudsman on PTSD, BGen (retired) Joe Sharpe, who invested countless hours of work, together with the Director of the Special Ombudsman Response Team, Gareth Jones, and my entire investigations and intake team.

1139 My extensive investigation into this issue has confirmed that PTSD is a very real illness that affects many CF members and their families. Far too many soldiers who have been diagnosed with this illness are being stigmatized, labelled as fakers, ostracized and isolated from the system that is supposed to support them. The fact that the situation has degenerated into one of name-calling in itself cries out for acts of leadership by CF authorities. It is apparent that when this disorder is effectively treated and strong supports are in place, members with PTSD can continue to contribute to the CF effectively. I was encouraged by the success stories we heard demonstrating that, contrary to popular belief, a diagnosis of PTSD is not always a one-way ticket out of the CF. Unfortunately, however, these success stories are still the exception, rather than the rule.

1140 It must be acknowledged that the CF has already taken many steps to better serve members with PTSD, as well as their families. CF leaders have made strong commitments to ensure the welfare of their troops.

1141 My Office is mandated to make long-lasting and substantial contributions to improve the lives of CF members and their families. It is my hope and desire that the recommendations contained in this report will be yet another step in achieving this mandate. This hope cannot be achieved, however, without the backing of DND/CF leaders. I urge them to view my recommendations, not as a condemnation, but as strong encouragement to further their commitment to CF members and their families.

1142 Many persons working within the system have demonstrated a strong and unrelenting dedication to serve their injured colleagues. Most recently, on 8 November 2001, LGen Couture, ADM (HR-Mil) as well as Col Scott Cameron, Surgeon General, testified at SCONDVA on efforts to deal with PTSD. Col Cameron commented that PTSD is "clearly one of the most significant health problems that our members face." Col Cameron agreed that improving mental health services is an ongoing concern.

1143 I believe significant steps must be taken to improve education and awareness of PTSD and its effects to change the climate of disbelief and scepticism surrounding this illness. Efforts and initiatives to care for members with PTSD must be co-ordinated to help as many as possible in the most effective and efficient ways. Adequate resources must also be put in place to ensure that those working in the system can do their jobs. Finally, there needs to be a fundamental shift to eliminate ineffective bureaucracy so that the needs of members are put before administrative details and concerns. The CF administration and support system need to adapt and change to serve the needs of injured members and not vice versa.

1144 I realize that placing more demands on resources is something much easier said than done in these difficult and uncertain economic times. However, if such resources are not made available now, the long-term costs to the CF as a whole will be immeasurable. Failure to deal effectively with this growing problem represents major consequences in terms of dollars lost in recruiting, educating and training soldiers who return from deployment with PTSD injuries only to be released from the CF. This failure has also imposed undue workloads on those who remain in the military, which has become increasingly understaffed.

1145 We must realize that money spent on the care of members who suffer from PTSD is an investment in people and in the future that will result in important dividends. Every dollar that is spent on education, treatment and support will be repaid tenfold in savings of dollars now being spent to recruit replacements for good soldiers who are needlessly lost. Furthermore, no dollar value can be put on the benefits to be gained in terms of the positive impacts on the quality of life of members with PTSD and their families, or on the improved morale and public perception that the CF is doing right by its own.

1146 Canadians are living in increasingly troubled times. Canadians wish to have a military that they can depend on to contribute to the defence of freedom and security in the world. Canada currently has the most CF members on deployment since the Korean War. The stress created by this ever-increasing operational tempo will soon reach a critical point. The costs of maintaining Canada's defence obligations go beyond replacing tanks and helicopters. The resources must be there to care for CF soldiers when they return from battle, so they will be healthy and ready to respond in the future.

1147 Some members of the CF, particularly those employed in human resources and health services, will point to the great strides the CF has made in the last few years in caring for members with PTSD. I applaud these much-needed improvements. However, much more needs to be done. We should not allow the good work already done to distract us from the work that remains to be done.

1148 Because of the importance of caring for CF members with PTSD, I intend to meet the appropriate CF/DND authorities to assist them in their consideration of my recommendations. A concerted effort between the organization and my Office, as well as the sharing of additional information and insight gleaned during the investigation, is essential for long-lasting improvements. I am committed to this concerted and collaborative next step.

1149 I also understand that the public has become more and more interested in the issue and how our military deals with members with PTSD. Given the high degree of public interest in resolving issues related to PTSD in the CF, I intend to publish, within nine months of the publication of this report, a follow-up report on the organization's progress in improving the welfare of its members with PTSD. Together, we can make a difference.

Summary of recommendations

1150 It is recommended that:

1151 1. The Canadian Forces develop a database that accurately reflects the number of Canadian Forces personnel, including members of both the Regular and Reserve Forces, who are affected by stress-related injuries.

1152 2. The Canadian Forces develop a database on suicides among members and former members.

1153 3. The Canadian Forces conduct an independent and confidential mental health survey that includes former members, as well as Regular and Reserve components.

1154 4. The Canadian Forces examine the issue of work therapy while on SPHL in more detail, with a view to creating policies and procedures to deal equitably with issues that arise from members on the SPHL earning secondary income from employment as part of a therapy program.

1155 5. The Canadian Forces initiate a program whereby all units receive outreach training about PTSD via the OTSSCs.

1156 6. OTSSCs be funded to a level that ensures they have sufficient resources to deliver quality outreach training to units on request.

1157 7. Specific and detailed education and training objectives dealing with PTSD be included in the curricula of all Canadian Forces educational and training establishments, and that the performance measurement criteria for these organizations reflect these objectives.

1158 8. Canadian Forces units be mandated to provide ongoing continuation training about PTSD to all members at regular intervals, in addition to any deployment-related training.

1159 9. The Canadian Forces make PTSD a mandatory part of education and training at all ranks and that educating Canadian Forces members about PTSD be made a priority.

1160 10. The Office of the PTSD co-ordinator play a central role in the education and training process by acting as a resource and advisor for bases, formations and commands.

1161 11. The Canadian Forces include members or former members who have experience of PTSD in all education and training initiatives relating to PTSD.

1162 12. Multidisciplinary teams that include all of the professional specialties with an interest in PTSD diagnosis and treatment, including experienced soldiers, be used to deliver outreach training. To enhance training effectiveness and ensure standardization, such training should fall under the control of the Office of the PTSD co-ordinator.

1163 13. The Canadian Forces allot additional resources to accelerate the implementation of the proposed mental health education initiatives developed by the Rx 2000 Mental Health Team.

1164 14. The Canadian Forces develop a standardized screening process that involves all of the pertinent specialists and that is under the control of a single point of contact.

1165 15. The Canadian Forces set up a pilot project to determine the most effective ways of allowing members returning from deployment to be reintegrated into family and garrison life.

1166 16. The Canadian Forces provide sufficient incremental resources to permit all mental health caregivers, including padres and social workers, to access training required to deal with mental health issues.

1167 17. The Canadian Forces provide sufficient incremental resources to permit the Canadian Forces social work branch to hold an annual retreat for all Canadian Forces social workers. PTSD should be a significant topic at the retreat.

1168 18. The rules regarding Occupational Transfer be changed to quickly accommodate members diagnosed with PTSD who would benefit therapeutically from working in another military occupation.

1169 19. The Canadian Forces audit and assess the effectiveness of policies and procedures designed to assist Reserve Force members and augmentees pre- and post-deployment.

1170 20. The Canadian Forces review policies and procedures with a view to making them as flexible as possible to accommodate the needs of members who have been diagnosed with PTSD and wish to remain with their units for as long as is possible.

1171 21. The Canadian Forces review procedures for placing members on the SPHL to ensure a greater role for input from Medical Officers and Commanding Officers.

1172 22. Units maintain contact with members on the SPHL bi-weekly, subject to any restrictions imposed by the member's treating caregiver, or any desire expressed by the member.

1173 23. The Canadian Forces address resource issues that are preventing units from properly looking after members diagnosed with PTSD within their units.

1174 24. The Canadian Forces prioritize and accelerate the efforts toward standardizing treatment of members diagnosed with PTSD among OTSSCs.

1175 25. OTSSCs be resourced on a priority basis, and to a level sufficient to perform all of their designated functions.

1176 26. The DGHS initiate a pilot project that locates one OTSSC off-base, to ascertain whether such an arrangement is better suited to the objectives of the OTSSC.

1177 27. The Canadian Forces take steps to deal with the issues of stress and burnout created by lack of resources and high caseloads among Canadian Forces caregivers.

1178 28. The Canadian Forces take steps to improve support programs designed for the families of members diagnosed with PTSD, at all elements and locations.

1179 29. The Canadian Forces continue support for the Operational Stress Injury Social Support initiative and provides resources as required to extend this or similar programs across the Canadian Forces.

1180 30. The Canadian Forces initiate an end-to-end review of the rules dealing with confidentiality of medical information. In the short term, breaches of confidentiality must be dealt with quickly and visibly to re-establish confidence in the Canadian Force's commitment to protect personal information.

1181 31. The Canadian Forces create the position of PTSD co-ordinator, reporting directly to the CDS and responsible for co-ordinating issues related to PTSD across the Canadian Forces.

List of abbreviations

1182	ACOS HS Del	Assistant Chief of Staff, Health Services Delivery
1183	ADF	Australian Defence Force
1184	ADM (HR-Mil)	Assistant Deputy Minister (Human Resources – Military)
1185	ALLC	Army Lessons Learned Centre
1186	AR/MEL	Administrative Review of Medical Employment Limitations
1187	ASU	Area Support Unit
1188	BG	Battle Group
1189	BGen	Brigadier-General
1190	Bn	Battalion
1191	BOI	Board of Inquiry
1192	BPSO	Base Personnel Selection Officer
1193	Capt	Captain
1194	CCHS	Canadian Community Health Survey
1195	CDS	Chief of the Defence Staff
1196	CF	Canadian Forces
1197	CFAO	Canadian Forces Administrative Order
1198	CFB	Canadian Forces Base
1199	CFC	Canadian Forces College
1200	CFChSC	Canadian Forces Chaplain School and Centre
1201	CFFA	Canadian Forces Fire Academy
1202	CFHIS	Canadian Forces Health Information System

1203	CFLRS	Canadian Forces Leadership and Recruit School
1204	CFMPA	Canadian Forces Military Police Academy
1205	CFMS	Canadian Forces Medical Services
1206	CFRETS	Canadian Forces Recruiting, Education and Training System
1207	CFRG	CF Recruiting Group
1208	CFSAS	Canadian Forces School of Aerospace Studies
1209	CIS	Critical Incident Stress
1210	CISD	Critical Incident Stress Debriefing
1211	CLFS	Canadian Land Forces Staff College
1212	CLS	Chief of Land Staff
1213	CO	Commanding Officer
1214	Col	Colonel
1215	Cpl	Corporal
1216	CRB	Career Review Board
1217	CRS	Chief Review Services
1218	CTC	Combat Training Centre
1219	CWO	Chief Warrant Officer
1220	DCSA	Director Casualty Support and Administration
1221	DGHS	Director General of Health Services
1222	DMCARM	Director Military Careers Administration and Resource Management
1223	DND	Department of National Defence

1224	DSM-IV	*Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition
1225	Gen	General
1226	HLIS 2000	Health and Lifestyle Information Survey 2000
1227	LCdr	Lieutenant-Commander
1228	LCol	Lieutenant-Colonel
1229	LFAA	Land Forces Atlantic Area
1230	LFCA	Land Forces Central Area
1231	LFWA	Land Forces Western Area
1232	LGen	Lieutenant-General
1233	Lt	Lieutenant
1234	Lt (N)	Lieutenant (Navy)
1235	MCpl	Master Corporal
1236	MFRC	Military Family Resource Centre
1237	MO	Medical Officer
1238	MOC	Military Occupation Code
1239	MP	Military Police
1240	MPHL	Medical Patient Holding List (now *SPHL*)
1241	MWO	Master Warrant Officer
1242	NATO	North Atlantic Treaty Organization
1243	NCM	Non-Commissioned Member (previously *other ranks*)
1244	NCO	Non-Commissioned Officer (now *NCM*)
1245	NDA	*National Defence Act*
1246	NDHQ	National Defence Headquarters

1247	NIS	National Investigative Service
1248	OC	Officer Commanding
1249	OPI	Office of Primary Interest
1250	OPP	Ontario Provincial Police
1251	OSISS	Operational Stress Injury Social Support
1252	OT	Occupational Transfer
1253	OTSSC	Operational Trauma and Stress Support Centre
1254	PMQ	Private Married Quarters
1255	POR	Post Operational Report
1256	PPCLI	Princess Patricia's Canadian Light Infantry
1257	PSO	Personnel Selection Officer
1258	PSTC	Peacekeeping Support Training Centre
1259	PTSD	Post Traumatic Stress Disorder
1260	RMC	Royal Military College
1261	SCONDVA	Standing Committee on National Defence and Veterans Affairs
1262	SISIP	Service Income Security Insurance Plan
1263	SME	Subject Matter Expert
1264	SPHL	Service Personnel Holding List
1265	SRB	Senior Review Board
1266	SWO	Social Welfare Officer
1267	TAP	Transition Assistance Program
1268	UN	United Nations
1269	UNPROFOR	United Nations Protection Force

1270	VAC	Veterans Affairs Canada
1271	VACSTC	Vernon Army Cadet Summer Training Centre
1272	WATC	Western Area Training Centre
1273	WO	Warrant Officer